FINAL REPORT

PROMOTING HEALTH REFORM IN THREE COUNTRIES IN CENTRAL AND SOUTH ASIA AND EAST AFRICA THROUGH INSTITUTIONAL CAPACITY BUILDING

GUJARAT HEALTH SYSTEM DEVELOPMENT PROJECT

(October 1998 – December 31, 2004)

Aga Khan Foundation U.S.A.

(Grant Agreement/Award no. FAO-A-00-98-00078-00)

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List of Abbreviations

AHF	Alternative Health Financing
AKDN	Aga Khan Development Network
AKES,I	Aga Khan Education Service, India
AKF	Aga Khan Foundation
AKF India	Aga Khan Foundation (India)
AKF USA	Aga Khan Foundation U.S.A.
AKHS,I	Aga Khan Health Service, India
AKPBS,I	Aga Khan Planning and Building Service, India
AKRSP	Aga Khan Rural Support Programme
ANC	Ante Natal Care
AWW	Anganwadi Worker
ANM	Auxiliary Nurse Midwife
BCC	Behavior Change Communication
BHR	Bureau for Humanitarian Response
CHF	Community Health Fund
CHV	Community Health Volunteer
CORT	Center for Operations Research and Training
DIP	Detailed Implementation Plan
EHS	Essential Health Services
FLE	Family Life Education
GBAO	Gorno-Badakhshan Autonomous Oblast
GHSDP	Gujarat Health System Development Project
GoI	Government of India
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HPDC	Health Professional Development Center
HRD	Human Resource Development
HRM	Human Resource Management
HSMC	Health Sector Management Committee
IEC	Information Education Communication
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MGIMS	Mahatma Gandhi Institute for Medical Sciences
MG	Matching Grant
MIS	Management Information Systems
MO	Medical Officer
MoU	Memorandum of Understanding
NCD	Non-Communicable Disease
OPD	Out Patient Delivery
PLA	Participatory Learning for Action
PNC	Post Natal Care
PRA	Participatory Rural Appraisal
PVC	Office of Private and Voluntary Co-ordination
QA	Quality Assurance
RCH	Reproductive and Child Health
RTI	Reproductive Tract Infections

SJHSP	Sidhpur and Junagadh Health Systems Project
SDC	Swiss Agency for Development Co-operation
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
VLC	Village Health Committee
USAID	United States Agency for International Development

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EXECTUVIVE SUMMARY

The *Gujarat Health System Development Project (GHSDP)*, implemented by the Aga Khan Health Service, India and managed by Aga Khan Foundation, India sought to improve the health status of 86,000 rural residents, primarily women of reproductive age (15-45) and children under three, in Patan, Banaskantha and Junagadh districts of Gujarat State, India. The Project was part of the fifth USAID Matching Grant awarded to Aga Khan Foundation U.S.A., entitled "Promoting Health Reform in Three Countries in Central and South Asia and East Africa through Institutional Capacity Building, Partnership Strengthening and Documenting and Disseminating Best Practices" and built upon achievements made during Matching Grant IV, previously awarded in 1994. This report is concentrated on the completion and achievements of the GHSDP. Other projects under the Matching Grant V were previously completed and closed-out.

The Project commenced in October 1998 and was initially scheduled to end on September 30, 2003. Due to a slow start-up, the 2001 earthquake and 2002 communal riots in Gujarat, a 15-month no-cost extension was granted by USAID, thereby changing the end date to December 31, 2004. In September 2000, an internal review required that the project team amend their strategies, interventions and activities based on a changed operating context and market feasibility analysis. Project objectives were revised and commensurate modifications were made in the Detailed Implementation Plan. After the Mid-Term Review conducted in September 2001, added emphasis was placed upon increasing cost-recovery and consolidating lessons learned as per the recommendations of the review team. A team of external health experts conducted a final evaluation as per grant requirements in October - November 2004.

The **goal** of the Project was to improve the health status of women of reproductive age (15-45 years) and children (0-3 years) in 55 villages of Junagadh, Patan and Banaskantha districts of Gujarat State, India. The Project aimed to reduce health disparities by establishing a three-tier system of community outreach, health and diagnostic centers. Emphasis was placed upon improving the quality of primary care services, enhancing access to secondary care and building the capacity of community-based organizations to manage their own health care initiatives. The project drew upon a large base of community health volunteers, primarily women, to ensure service delivery at the household level and to facilitate health promotion, gender sensitization and behavior change in the target population.

The Project worked towards achievement of its goal through the following **objectives**:

1. Enhancing the quality and extending the range of diagnostic and essential health services in existing project areas and expanding coverage to an additional 15,000 residents, thus serving a total population of 86,000;
2. Enhancing organizational effectiveness by introducing comprehensive systems for human resource development, management and finance;
3. Increasing the financial sustainability of the network of facilities in Patan and Junagadh districts; and
4. Documenting and sharing project outputs, best practices and lessons learned with

key stakeholders.

Table 1 contains information on the geographic reach of the Project and its beneficiary population.

Table 1: Project Beneficiaries (November 2004)

Gujarat Health System Development Project		Junagadh	Sidhpur	Total
A	Total # of Households	8,051	8,493	16,544
B	Total Population	41,294	42,511	83,805
C	Direct beneficiaries: Women of reproductive age (15-45)	13,102	7,889	20,991
D	Direct beneficiaries: Children (0-3)	2,733	2,304	5,037
E (C + D)	**Total Direct Beneficiaries**	**15,835**	**10,193**	**26,028**

Key Achievements against Objectives

Objective 1: Access and Coverage

- Marked improvement in the coverage of basic reproductive and child health services to levels well above state and national averages, particularly in the area of preventive and promotive care. As reported in June 2004**,** 91% of newborns were breastfed within eight hours of birth, 84% of children were fully immunized before their first year, and 69% of antenatal women were registered within their first trimester.
- Consistent commitment to quality services, including the development of protocols for the delivery of each of the Project's nineteen essential health services, translated into the local language and distributed for use in each health center. Concomitant development of Standard Operating Procedures and Quality Assurance Checklists.
- Successful replication of the service delivery model in two villages of Patan District within a relatively short period of the time with achievement of almost 100% cost recovery at health centers.
- Successful facilitation of improved preventive and promotive heath care at the village level and attendant health gains achieved in six villages of Junagadh District through strengthening and facilitation of partnerships between AKHS,I, communities and local public and private health care providers.

Objective 2: Capacity Building

- Effective development and mobilization of a highly skilled base of community health workers and volunteers who provided the crucial link between Project beneficiaries and staff.
- Strengthened partnerships with communities through the establishment of village-level committees, thereby empowering them to better understand and express their health needs and exercise appropriate demand for services on local public and private health care providers.
- High levels of participation and contribution from village-level committees and community health volunteers in terms of capital, time, in-kind donations, etc., thereby creating a strong sense of community ownership amongst beneficiaries.
- Built expertise in the area of behavior change communication, including the development of a package of messages illustrated through colored posters and flashcards translated into the local language and distributed for use in each health

center.

Objective 3: Financial Sustainability

- Establishment of four community-managed health centers in villages of Patan District built with a large portion of capital costs donated by community members and with cost recovery rates consistently above 50%.
- Participation among communities in Alternative Health Financing schemes contributing towards recovery of direct costs, including pre-paid community health insurance and secured annual financial commitments ranging between $320-640 from local dairy co-operatives of two villages in Patan District.
- Strong commitment to financial sustainability at all levels, with cost-recovery rates consistently remaining above 40% for health centers and above 60% for diagnostic centers since Project inception. As of September 2004, the network of facilities achieved an average cost-recovery rate of 60%.

Objective 4: Documentation

- Completion of VOICES, a series of qualitative life stories of community health workers, volunteers and the community
- Descriptive case studies on the *replication* and *facilitation* models of health systems (described under Section IIC), respectively being implemented in the new villages of Patan and Junagadh Districts.
- Film on the project to be used for information sharing and training
- Completion of an end-line survey that provided quantitative estimates of RCH indicators (both practice and knowledge) to enable an understanding of the Project's success in achieving its goal.

Challenges and Lessons Learned

- Unpredictable market dynamics, provider competition and high staff attrition adversely affected the quality and continuity of services. These aspects of service delivery are equally as important as affordability and accessibility in sustaining community interest, ensuring participation and maintaining utilization rates.
- While health centers were not able to generate sufficient revenues to fully cover costs (costs in any year approximately doubled revenue), diagnostic centers were able to do so. Consequently, the model of cross subsidization, while viable in principle, was threatened as a result of staff attrition and provider competition. Therefore, sustained cost recovery of the overall network of facilities cannot be expected to exceed 60-70%.
- Participation of women and minority ethnic groups in Health Sector Management Committees did not reach desired levels. As the local marketing functions of these Committees play a key role in ensuring utilization and sustainability of health centers, they must represent a cross-section of the village population in order to first be accepted by the community.
- Service delivery proved difficult in parts of Junagadh District due to low socio-economic conditions and provider competition. The *facilitation* model of improving existing health services has proved to be as, if not more, important than direct service delivery.

Budget vs. Actual Utilization

The Project's six-year budget was a total of $2,107,909, out of which 87% or $1,823,583 was utilized. Taken together, USAID and AKF USA contributed 75% of the Project's entire funding, the remaining 25% of which was obtained from other sources, i.e. community contribution and health facility income. Overall, the Project was able to utilize allocated funds as per approved budgets, with under-spending taking place at the nominal average rate of 14 % per year. Low utilization of funds occurred primarily under the Consultant and Equipment line items, with over-spending at times taking place in the Personnel and Supplies line items.

The end-of-project report spans the entire Project period from October 1998 to December 2004. The report contains a brief history to the Project, details the process by which it was made operational, and covers progress against objectives as per the Detailed Implementation Plan.

I. BACKGROUND TO GRANT AND PROJECT CONTEXT

The Aga Khan Development Network (AKDN) is a group of private development agencies working to empower communities and individuals, often in disadvantaged circumstances, to improve living conditions and opportunities, primarily in Africa and Asia. Its agencies work in over 30 countries for the common good of all citizens regardless of their gender, origin or religion. Its underlying impulse is the ethic of compassion for the vulnerable in society.

Aga Khan Foundation (AKF) is a non-denominational, international development organization established to promote social development through innovative approaches to health, education and rural development. Cross-cutting concerns include gender equity, environment, sustainability, community participation, human resource development and the strengthening of civil society.

Aga Khan Foundation U.S.A. (AKF USA) was awarded its fifth Matching Grant (MG V) in 1998 from the Office of Private and Voluntary Cooperation (PVC) in the Bureau of Humanitarian Response (BHR) of the United States Agency for International Development (USAID). MG V was directly preceded by Matching Grant IV (MG IV) and its design was influenced by the systems approach to health reform of MG IV.

A. Matching Grant IV (1994-1998)

In India, MG IV supported the Sidhpur and Junagadh Health System Project (SJHSP), conducted from 1994-1998 in the same two districts of Gujarat State, India as those selected in MG V: Patan and Junagadh. Like GHSDP, the goal of the project was the sustainable improvement in health status of women of reproductive age and children under three. The central achievement of SJHSP was the establishment of an impressive infrastructure, both physical and human, that delivered an integrated package of family health services in remote areas and extensively included community groups in the planning and management of essential health care initiatives. By the end of MG IV, the project had exceeded a number of its service delivery targets and had made considerable progress towards achieving financial sustainability; in 1996, recovery of direct costs reached a high of 75% at the Sidhpur project site[1].

Recommendations from the SJHSP final evaluation suggested that operations should be expanded to other areas through replication of its facility-based model of health service

[1] The Sidhpur Project area includes villages located in the Districts of Patan and Banaskantha.

delivery and by capitalizing upon the infrastructure already in place. In concurrence with other recommendations made during the final evaluation, it was felt that existing disparities in the health status among groups of differing socio-economic standing ought to be addressed through a follow-on project.

A key lesson from of MG IV that shaped the design of MG V was that, in the Indian context, it is extremely difficult to maintain a stable client base solely through provision of primary health care services. Hence, between 1994-1996, in addition to increasing the number of health centers providing basic curative care at the village level, diagnostic centers with modern laboratories were also constructed to offer sonography, pathology and radiology services through a referral system. Fifteen health and three diagnostic centers had been built by the end of MG IV in September 1998. Following this trend, MG V initially proposed to go a step further and develop maternity homes, blood banks and urban polyclincs offering specialized care. Revenue made from user fees collected at the diagnostic centers and specialty clinics was to cross-subsidize the operational costs of the health centers and contribute to even greater levels of financial sustainability than those witnessed during MG IV (originally targeted at 90% under MG V).

B. Matching Grant V (1998-2004)

It was in this milieu of progress and institutional knowledge that MG V arose. The **goal** of MG V was to achieve sustainable improvements in the health status of women and children in Tajikistan, India and Kenya by fostering health reform, a process that addressed long-standing constraints to efficient resource management and effective health service.

The overarching **objectives** of MG V were to:

1. Introduce or refine policies that support greater efficiency, effectiveness and sustainability of basic health services;
2. Enhance prospects for sustainable financing of basic health services at the local or regional level; and
3. Improve the accessibility, quality and equity of basic health services.

In order to achieve these objectives, AKF supported the following six interventions designed to build the institutional capacity of local and international health organizations, strengthen partnerships among stakeholders and document and disseminate best practices for informing health policy and practice at local, national and international levels:

- The *Gujarat Health System Development Project* implemented by the Aga Khan Health Service, India.
- *Building Capacity for Restructuring and Reforming the Health Sector* in the Gorno-Badakshan Autonomous Oblast of Tajikistan implemented by AKF (Tajikistan) in collaboration with the Department of Health.
- *Rationalizing Pharmaceutical Policies, Practices and Management* in the Gorno-Badakshan Autonomous Oblast of Tajikistan implemented by AKF (Tajikistan) in collaboration with the Department of Health.
- *Improving Reproductive Health and Child Survival Services* in the Gorno-

Badakshan Autonomous Oblast of Tajikistan implemented by AKF (Tajikistan) in collaboration with the Department of Health.

- *Strengthening the Institutional Capacity of Aga Khan Health Service, East Africa's Community Health Department to Support Organizations Working in Community Health*, implemented by Aga Khan Health Services, Kenya.
- *Management, Monitoring and Institutional Learning*, implemented by Aga Khan Foundation U.S.A.

C. Matching Grant Strategy and Approach

The objectives of MG V directly responded to AKF's interest in achieving sustainable developments in maternal, child and reproductive health. The strategy employed in MG V builds upon AKF's experience gained through previous USAID Matching Grants in implementing community-based health programmers and strengthening the capacity of local institutions to effectively manage health systems.

D. Funding Amounts

The total five-year budget (1998-2003) for all five programs and the Management, Monitoring and Institutional Learning activity under MG V was $5,083,000. The budget anticipated a contribution of $2,000,000 (39% of the total) from USAID and $3,083,000 (61%) in nonfederal cost share from AKF USA donations and other sources, specifically the Swiss Development Corporation (SDC).

Both the USAID and nonfederal cost share portion of the grant were under spent by a total of $426,900.63 ($128,333 USAID and $298,567 nonfederal). Of the budgeted amounts, the total nonfederal actual expenditures was 90.32% ($2,784,433) of which $1,932,463 came from AKF USA contributions and $851,970 came from SDC contributions. The USAID portion of actual expenditures was 93.58% ($1,871,667). Thus, the final cost share was 40.2% for USAID and 59.8% from nonfederal sources.

II. INTRODUCTION TO THE GUJARAT HEALTH SYSTEM DEVELOPMENT PROJECT

The *Gujarat Health System Development Project* (GHSDP) was implemented by the Aga Khan Health Service, India (AKHS,I) and managed by Aga Khan Foundation, India (AKF India).

AKF was established in India in 1978 as an international non-governmental organization and provides financial and technical assistance to grantees and partners in the fields of community health, education and rural development primarily in the country's Western and Central states.

The Aga Khan Health Service, India (AKHS,I), incorporated as a service company in 1986, is one of the largest not-for-profit, private health care organizations in India. AKHS,I's mission is to provide access to quality, comprehensive health care and to promote physical, social and mental well-being based on the principles of volunteerism

and community participation. AKHS,I works towards fulfilling its mission by delivering quality essential services for preventive, promotive and curative health care to poor communities in rural areas of Western and Central India through its 22 health and diagnostic centers.

A. Project Goal: To improve the health status of women of reproductive age (15-45) and children (0-3) in the project area. GHSDP sought to improve the health status of approximately 86,000 rural residents in Patan, Banaskantha and Junagadh districts of Gujarat state, India, primarily women of reproductive age (15-45) and children under three (See Annex 1 for AKHS,I mandate, Annex 2 for maps and Annex 3 for a list of project villages). The project aimed to reduce health disparities by establishing a three-tier system of community outreach, health and diagnostic centers. Emphasis was on improving the quality of primary care services, enhancing access to secondary care and building the capacity of community based organizations to manage their own health care initiatives. The project drew on a large base of community health workers and volunteers, primarily women, to ensure service delivery at the household level and facilitate health promotion, gender sensitization and behavior change.

The objectives of GHSDP were to:

1. Enhance the quality and extend the range of diagnostic and essential health services in existing project areas and expand coverage to an additional 15,000 residents, thus serving a total population of 86,000;
2. Enhance the organizational effectiveness of AKHS,I by introducing comprehensive systems for human resource development, management and finance;
3. Increase the financial sustainability of the network of AKHS,I facilities in Sidhpur and Junagadh; and
4. Document and share project outputs, best practices and lessons learned with key stakeholders (communities, government, AKF, USAID, NGOs, private sector providers)

B. Project Milestones

1. October 1998 – Award of grant

The USAID Cooperative Agreement was approved and dispatched to AKF USA in the months preceding the start of the grant. Grant letters between AKF and AKHS,I were subsequently signed to guide the Project's first year of progress. Shortly thereafter, preparations began for the baseline survey, which was to be conducted in early 1999.

2. September 2000 – Internal review

AKHS, I and AKF India carried out a joint review of the Project two years after inception. The purpose of the review was to revisit the original proposal, review progress to date and revise the goal and objectives in light of changed demographic trends among the beneficiary population and shifts in reproductive and child health policy at the national level (See Annex 4 for Detailed Implementation Plan). As a result, the goal was broadened as shown below in Table 2:

Table 2: Original and Revised Goal of the Project

Original Goal (1998)	To continue to improve the health status of communities in Junagadh and Patan Districts of Gujarat State, India and sustain these improvements by establishing a three-tier health system that will be 90% operationally self-sufficient by the end of the project period.
Revised Goal (2000)	To improve the health status of women of reproductive age (15-45) and children (0-3) in the project area.

The objectives of GHSDP were also refined, and reflect the thematic components of the national Reproductive and Child Health (RCH) program, showing a commitment to improving RCH status within Gujarat. (See Annex 5 for rationales for revising objectives and Annex 6 for a list of the project's Essential Health Services). The objectives were made to be more realistic given the challenges posed by increased competition from private providers, and laid clear emphasis on quality assurance, capacity building, financial sustainability and documentation of best practices.

1. September 2000 - Mid-Term Review

An external Mid-Term Review was conducted one year after the joint internal review. The overall assessment of the project was positive, with particular praise given to the wide degree of service coverage, high cost-recovery rates achieved across the network of facilities and unique potential of the *facilitation* model to create long-term health benefits using cost-effective methods and local resources. However, attention was drawn to the fact that in light of Project revisions stemming from the previous review, a clear strategy ought to have been devised to provide an expanded set of essential RCH services while simultaneously contributing towards financial sustainability of facilities – a central challenge facing community health programs throughout the developing world. The Mid-Term Review team concluded that the expanded package of health services needed to be more focused on the actual health needs of the beneficiary population, Behavior Change Communication (BCC) strategies would best be tailored for a particular set of key interventions, and that more effort was required in consolidating lessons learned and documenting best practices. Refer to Annex 7 for a full list of recommendations and actions taken until January 2004.

2. November 2002 – No-Cost Extension

The unanticipated revision of project objectives and interventions significantly altered the Project's scope of work and contributed to unforeseen delays in implementation. Further slowing down productivity were the combined effects of a devastating earthquake in January 2001 and outbreak of communal riots in April 2002. In order to allow the Project to complete its amended course of action and to execute the great number of

recommendations made during the Mid-Term Review, a 15-month no-cost extension was proposed and subsequently approved by USAID. The additional time was used to enable consolidation of lessons learned, focus on implementation of the *facilitation* model of health care in Junagadh district and devise a sustainable exit strategy for the Project.

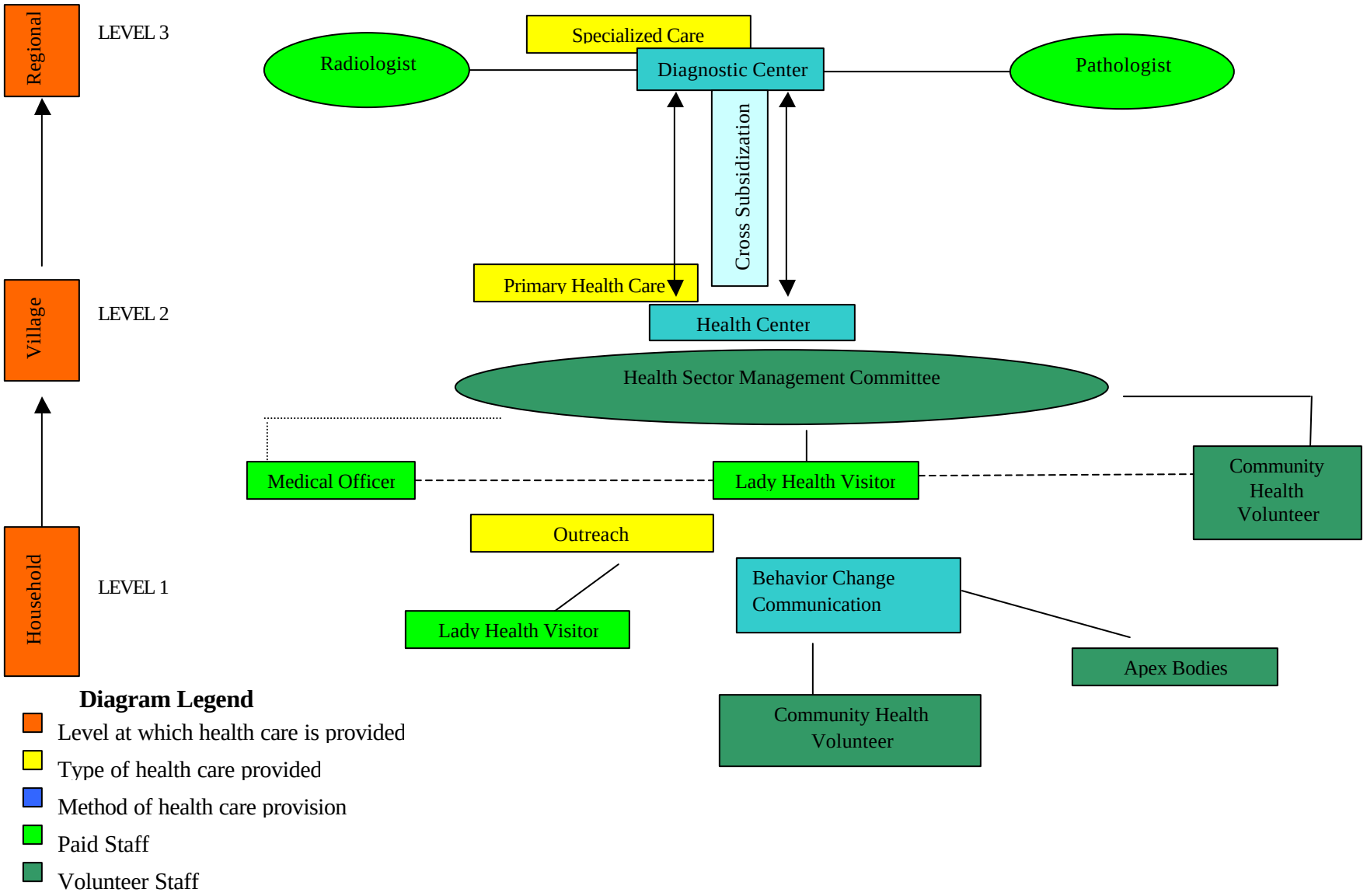
3. November 2004 – Final Evaluation

To fulfill grant requirements, assess trends in progress and inform future planning, a Final Evaluation was conducted two external health professionals in October – November 2004. Key findings brought attention to the Project's success in providing quality services and ensuring recovery of costs, creating high levels of health awareness and community participation and strong potential for scaling-up the *replication* and *facilitation* models of health care delivery. The evaluation team concluded its efforts by recommending that AKHS,I place concerted efforts on handing over health centers to the community, develop new organizational roles and competencies, incorporate changed demographic trends into future programming and document experiences with cost-recovery (Refer to Annex 8 for Final Evaluation report).

C. Operational Framework

AKHS,I's fixed-facility approach to the development of its rural community-based health system consisted of three core components: outreach, health and diagnostic centers. Diagram 1 below illustrates these components, the level in the overall health system at which they were placed, and the human resources required for their implementation.

Diagram 1: Operational Structure of the Gujarat Health System Development Project



Under MG IV, AKHS,I had put into place a human resource infrastructure of community health workers, which greatly facilitated the Project's expansion to new areas. In addition to staff at the district and state levels, this infrastructure consisted of five categories of personnel, both paid and volunteer: 1) Medical Officers; 2) Lady Health Visitors and Lady Health Visitor Supervisors; 3) Community Health Volunteers; 4) Health Sector Management Committees; and 5) Pathologists and Radiologists (Refer to Annex 9 for AKHS,I Organogram).

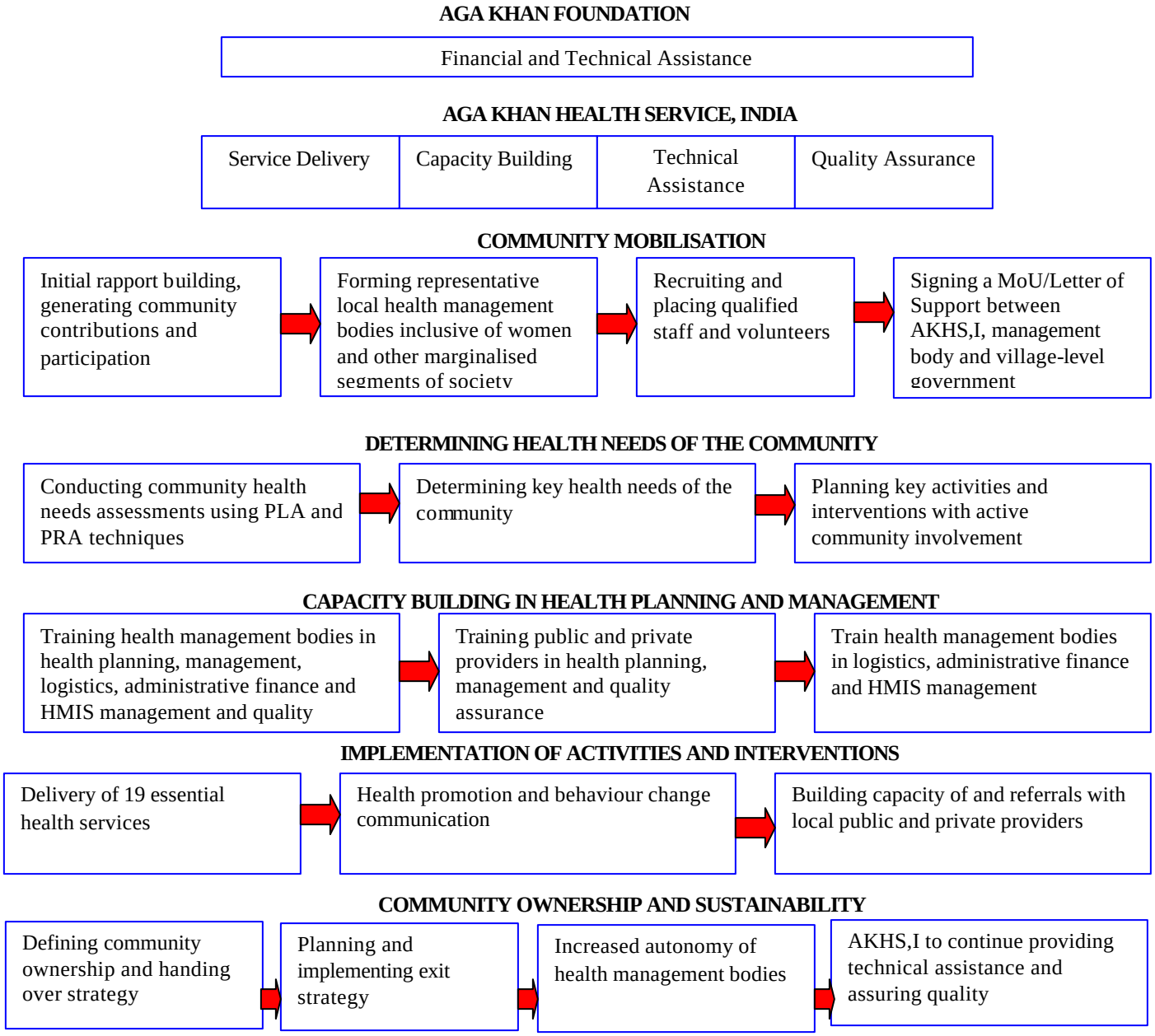
At the first level, Community Health Volunteers (CHVs) and Lady Health Visitors (LHVs) were responsible for health education, gender sensitization and behavior change communication at the individual and group levels. CHVs were women from various ethnic groups trained by AKHS,I to complement the role of the LHV by providing promotive care at the household level, i.e. growth monitoring. At the second level, each health center served a cluster of villages with populations ranging from 3-5,000. Health centers were the points of contact for primary health care, where Medical Officers (MOs) and LHVs provided preventive, promotive and curative services to all beneficiaries in the project area. The all-volunteer governing bodies of each health center, known as Health Sector Management Committees (HSMCs), consisted of local men and women representing different ethnic groups appointed for one-year terms with sanction from AKHS, I. Each Committee was comprised of a convener, secretary and members who met on a monthly basis and were actively involved in the planning of health activities and financial and administrative management of health centers (See Annex 10 for HSMC roles and functions). Both CHVs and LHVs reported directly to and were supervised by HSMCs. Finally, at the third level, pathologists and radiologists provided specialized services at the Project's three diagnostic centers on a referral basis with Project health centers and other local health providers.

Recognizing that quality primary health care services were not likely to generate sufficient revenues to be financially sustainable, revenues from the diagnostic centers were used to subsidize the health centers' direct operating costs. In addition, revenue was generated in the form of user fees from routine delivery of Out Patient Department (OPD) services, special screening camps such as those for non-communicable diseases, and community health insurance schemes. As described above, the Project's standard model of health care delivery experienced moderate success in using this operational framework, the details of which are discussed in Section III.

D. Key Implementation Processes

The project employed five different key implementation processes, as illustrated in Diagram 2 below.

Diagram 2: Key Implementation Processes



Community Mobilization

Community mobilization was a critical first step, which was persistently undertaken with an understanding of and sensitivity for the community's needs and concerns. It was at this point when AKHS,I introduced itself into villages and relayed its mandate, values and objectives of GHSDP to the community. This process initially took several months of concerted effort through meetings with village leaders, community-based organizations and health providers to get a sense of the community's interest in participating in the Project and the types and levels of inputs required to carry out selected interventions. AKHS,I also recruited MOs and LHVs and identified qualified women to serve as CHVs. Final outputs of the process were the inauguration of health centers and signing of Memorandums of Understanding (MoU) and Letters of Support in which the roles and responsibilities of the health management bodies and AKHS,I were clearly delineated and agreed upon (See Annex 11 for Community Mobilization Timeline).

Determining Health Needs of the Community

In all Project villages, this process determined the key health issues facing a community and the interventions and activities to be undertaken to remedy such issues. Village mapping, health facility assessments and extensive discussions with village leaders, community-based organizations and local public and private providers ensued. Simultaneously, Participatory Rural Appraisals (PRA) and focus group discussions were conducted to determine the health needs of the population. Care was taken to obtain information from both women and men in a cross section of socio-economic, religious and ethnic groups. The results of these exercises were shared back with the community and select activities and interventions were collectively agreed upon under the direct guidance of Project staff to assure their appropriateness and quality.

Capacity Building in Health Planning and Management

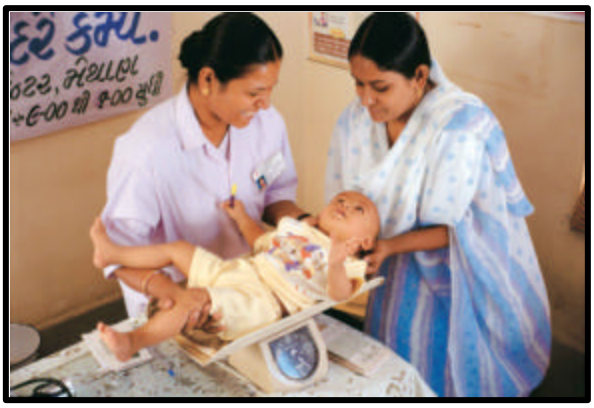
All AKHS,I staff and volunteers were primarily trained the Project's nineteen essential reproductive and child health services. In addition to health specific trainings (i.e. safe delivery and growth monitoring) orientations, trainings were imparted to the pertinent staff and volunteers on the following topics:

- Proper methodology for conducting household visits
- Proper methodology for conducting integrated OPD
- Methods for ensuring and maintaining community participation
- Methods for assuring quality of services
- Basic record keeping for tracking expenditure and income
- Basic record keeping for tracking routine MIS data from household visits
- Basic human resource and stocks management

Refresher trainings were carried out as and when required, and self-evaluations were conducted periodically at select training sessions.

Implementation of Activities and Interventions

As previously illustrated in Diagram 1, activities were implemented at three levels: household, village, and regional. At the household level, CHVs and LHVs responsible for promotive care and health education conducted BCC sessions with individuals and groups of women of reproductive as per the packages of messages designed for each of the nineteen essential health services. Household visits were also conducted for ante and postnatal women as well as for high-risk patients. Their health status was routinely monitored by LHVs and reported back at the health center.



Medical Officers (MOs) possessing at least an M.B.B.S degree were placed at health centers for four hours every alternate day to conduct OPD and tended to communities' need for curative care. LHVs qualified by Government of India (GoI) standards were responsible for assisting MOs with OPD for the first half of the day and providing preventive activities in their service area for the second half of the day, such as registration of pregnant women, ante, intra and postnatal care, and immunization. In addition, LHVs conducted an organized field activity per week (i.e. immunization drive or pap smear camp) and maintained financial, MIS and medical stock records of the health centers for routine reporting purposes. Referrals were made at the health center for specialty services delivered through the sonography, pathology and radiology labs at the Project's two diagnostic centers. Collaboration and networking with public and private providers also took place. Family Life Education (FLE) was conducted at 11 secondary schools across the Project area, and preventive health and screening camps and other awareness activities were periodically conducted in Project villages of both districts (See Annex 12 for Family Life Education Curricula and Participating Schools).

Community Ownership and Sustainability

The notion of community ownership and sustainability of health gains was impressed upon HSMCs/VLCs from the very outset to encourage greater participation in the planning and execution of community-based activities for and by community members. The sense of ownership is both literal and figurative as communities generated substantial resources towards the establishment of the centers, including donation of land, time and capital. At mid-term, the question of exit by AKHS,I was introduced to the Committees, to start the process of preparing for eventual handing over of increased control of health initiatives. Capacity building was intensified, future roles were clarified and agreed upon, and inputs by AKHS,I minimized (See Annex 13 for Exit Strategy Plan).

E. Two Approaches to Refining the System: Replication and Facilitation Models

In order to test the standard model's comparative effectiveness in achieving desired health impacts, AKHS,I employed two alternative models to refine the health system developed under MG IV: *Replication* and *Facilitation*. Table 2 below illustrates the animating features of each model (See Annex 14 for details of Replication and Facilitation models).

Table 2: Central Features of the Replication and Facilitation Models

Characteristic	Replication Model	Facilitation Model
Location in Project Area	Four villages in Patan District	Six villages in Junagadh District
Strategy	Facility-based service delivery	Partnerships between community-based stakeholders and quality public and private providers
Local Management Body	Health Sector Management Committee	Village Level Committees and Apex Body (consists of at least 1 representative of VLC and public and private providers)
Key Activities	• **Preventive care**: First trimester registration of pregnant women; ante, intra and post natal care; immunization • **Promotive care**: Contraceptive coverage; appropriate breastfeeding techniques; growth monitoring • **Curative care**: Out-patient service delivery at health centers • Trainings for HSMCs, CHVs, etc. • Health and screening camps • Health education, gender sensitization, behavior change communication • Routine monitoring and reporting • Monthly Health Sector Management Committee meetings	• **Networking and collaboration** between community stakeholders and public and private providers • **Health education**, gender sensitization, behavior change communication • **Trainings and capacity building** in health planning and management • Monthly Village Level Committee and Apex Body meetings:

The *replication* model of improving health status entailed expansion of activities, including service delivery, through the replication of community-managed health centers in three additional villages in the Sidhpur area of Patan district. This approach was used in Sidhpur as initial discussions with communities showed their willingness and ability to contribute capital and human resources towards the construction, management and maintenance of health centers. Simultaneously, in six additional villages in Junagadh district, AKHS,I implemented its *facilitation* model by which it sought to achieve improved health status by facilitating partnerships between community-based organizations and public and private providers of quality health care, enabling the former to effectively express their health needs and exercise appropriate demand on the latter. This less costly approach to improving health status was undertaken in Junagadh district as beneficiaries in this area were of poorer socio-economic status than their counterparts in Patan, and as in recent years the area had witnessed a proliferation of private providers competing with AKHS,I for a segment of the market share.

III. PROGRESS AGAINST OBJECTIVES AS PER DETAILED IMPLEMENTATION PLAN

Objective 1: Enhance the quality and extend the range of diagnostic and essential health services in the existing project area and expand coverage to an additional 15,000 residents

A. To ensure the quality of essential health services

The first challenge in implementing the revised objectives was to ensure uniformity of the expanded package of essential health services across all health and diagnostic centers. This necessitated the creation of protocols for all nineteen essential health services, as well as the development of an Essential Drugs List, Health and Nursing Protocols and HMIS and house-listing manuals. This gargantuan task took several years to complete, and was successfully concluded by October 2002. All protocols were translated into Gujarati, the local language, and distributed to each facility. Trainings to build staff capacity in the implementation of these protocols has been ongoing for the past year and a half. The issue of improving the quality of services across the three levels of the health system was addressed by the development of Quality Assurance (QA) Checklists and Standard Operating Procedures (SOP), all of which were finalized in mid 2004, translated into Gujarati and followed by capacity building trainings for key staff.

B. To extend the range of diagnostic and essential health services

In addition to adding family planning and reproductive health services to the package of essential health services, the Project also added histopathology, bacteriology and HIV/AIDS screening services at diagnostic centers, which resulted in increased utilization and cost-recovery. In addition, awareness promotion regarding STI/RTIs and HIV/AIDS proved to be a topic of interest to the community and in turn generated a thirst for more health education. The field testing of FLE in four replication villages in Patan district was successful and FLE was incorporated into the 8^{th}-10^{th}-grade curriculum of 11 local secondary schools, 1 of which was operated by the Aga Khan Education Service, India (AKES,I).

C. To extend the range of services to an additional 15,000

The Project has been immensely successful in expanding coverage to additional beneficiaries, through implementation of activities in nine new villages (six Junagadh and three in Sidhpur) using the two different delivery models of *replication* and *facilitation* as outlined in Section IIC above.

Objective 2: Enhance the organizational effectiveness of AKHS,I in human resource development, management and finance

A. Introduce a comprehensive human resource management system

A fair deal of activities was conducted as per the major heads under this objective, though progress made leaves room for further achievement. Human Resource Management (HRM) systems were closely scrutinized through an external audit in 2000, the recommendations of which spurred much activity, namely: revision of AKHS,I's Human Resource (HR) policy

and refinement of their HR manual; streamlining of recruitment and performance management systems; and reforms yielding a leaner organizational structure. However, the organization continued to be dogged by high staff turnover at all levels, from CHVs to middle management. This persistent phenomenon has not only caused disruptions in implementation of project activities, but has also placed unforeseen added stress on project staff to continually invest more of their energy towards recruitment, orientation and training of new staff members.

B. Establish and make operational the Health Professional Development Center

Achievement of this objective would have greatly been improved had the project been able to fulfill the potential of the Health Professional Development Center (HPDC) located in Jonpur village of Junagadh District. HPDC was originally constructed with the intention of developing capacity of health professionals, both internal to AKHS, I, as well as local NGOs, government functionaries, etc., through trainings, seminars, workshops and conferences on a variety of health-related topics. Though the center was heavily used for internal trainings, marketing strategies failed to materialize in increased utilization by external agencies. The current plan is to use HPDC as a training center and meeting space for all AKDN agencies active in and around Junagadh District.

C. Build capacities of staff and volunteers

Training needs assessments, training of trainers and refresher courses on technical topics relevant to each category of personnel were regularly conducted from the outset. These sessions were found to be useful in building capacities of staff and volunteers and aligning their skills to the expanded set of essential health services. See Annex 15 for a list of trainings imparted since Project inception.

D. Develop behavior change communication strategies to address emerging needs

The Project was able to produce Behavior Change Communication (BCC) packages comprised of illustrative flashcards, flip charts and posters for the entire set of essential health services, all of which have been translated into the local language and distributed across all (See Annex 16 for a list of BCC materials developed). CHVs and LHVs have been trained in how to appropriately utilize these materials as part of their health promotion and BCC activities. It is with these aids, in conjunction with a trained and dedicated cadre of LHVs and CHVs that has enabled the project to improve the health status among its direct beneficiaries to such a high degree, particularly in the areas of prevention and promotion.

E. Improve management systems

Though initialized at a date much later than anticipated, the Management Information System (MIS) was completed and customized to project requirements in 2002. This enabled the project team to carry out a household enumeration study in all villages in the same year, the data from which was cleaned and made available in March 2003. Installation and streamlining of the MIS was slow due to lack of sufficient numbers of staff at the field and central offices responsible for data entry and management. However, the system is fully operational and regularly provided data for management purposes and to help track health improvements.

F. To improve finance systems

Capacities of staff in finance have been somewhat strengthened over the course of the Project, particularly at the field level. The core achievement in this regard has been success in training HSMCs in proper record keeping and financial management at the health center level. This is a key part of the exit strategy process and has resulted in communities feeling more capable of assuming greater for health center management in the future. In this sense, such progress can be seen as contributing to the overall financial and operational sustainability of certain health centers.

Objective 3: Improve financial sustainability of the network of facilities in the project area

A. Hand over at least four health centers to the community

The Project team in this area has long since devised an exit strategy intended to hand over increased control to the HSMC in the day-to-day management of the health centers. Solid progress has been made on this front, with numerous trainings programs held for HSMCs, LHVs, and CHVs in health planning and management, financial, MIS and equipment/stocks management, logistics and administration of staff, etc. Communities in these four villages have continually expressed eagerness to see the handing over process through to completion, and have been made aware of AKHS,I's intention to continue acting as a guarantor of quality and provider of technical assistance after handing over has occurred.

B. Develop and introduce alternative health financing mechanisms

In a fixed-facility health system such as that of GHSDP, it is critical to offer a comprehensive basket of curative, preventive and promotive services that result in positive health gains at the community level, while also contributing towards financial sustainability. In this scenario, it is well known that the majority of revenue is generated through curative service delivery, and not through preventive and promotive care. Equally pertinent for AKHS,I has been the constant tension between increasing revenues and assuring quality through the practice of rational medicine. Faced with these realities, AKHS,I chose to continue to provide preventive and promotive services and to maintain quality in spite of it being evident that direct operating costs of the network of fixed facilities would never be fully recovered through income generated by curative service delivery.

To recover costs, AKHS,I instituted three revenue-generating mechanisms:

a. User Fees
b. Special Camps

c. Community Health Financing/Alternative Health Financing

Given these realities, Alternative Health Financing (AHF) mechanisms such as 1) Pre-paid family health insurance whereby, for 150 Indian Rupees (INR) a year, health center registration and consultation fees are waived and certain diagnostic services discounted; 2) Community Health Funds (CHF) wherein local dairy co-operatives provide annual lump sums towards operating costs of health centers in their village and; 3) Health, screening and multi-diagnostic camps based on needs expressed by communities (See Annex 17 for detailed definitions of AHF). Table 5 provides a village-wise list of the number of AHF packages registered to date:

Table 5: Number of AHF and CHF Packages in the Project Area (November 2004)

Village	Type of Package	Number of Packages
Jonpur	AHF	69
Badodar	AHF	5
Malia	AHF	1
Gangecha	AHF	55
Sangodra	AHF	33
Chitravad	AHF	19
Methan	CHF	40
Samoda	CHF	3
Punasan	CHF	15
Varshila	CHF	12
Meloj	AHF/CHF	572
Total		**824**
Aga Khan Hostel, Malia		206
Grand Total		**1,030**

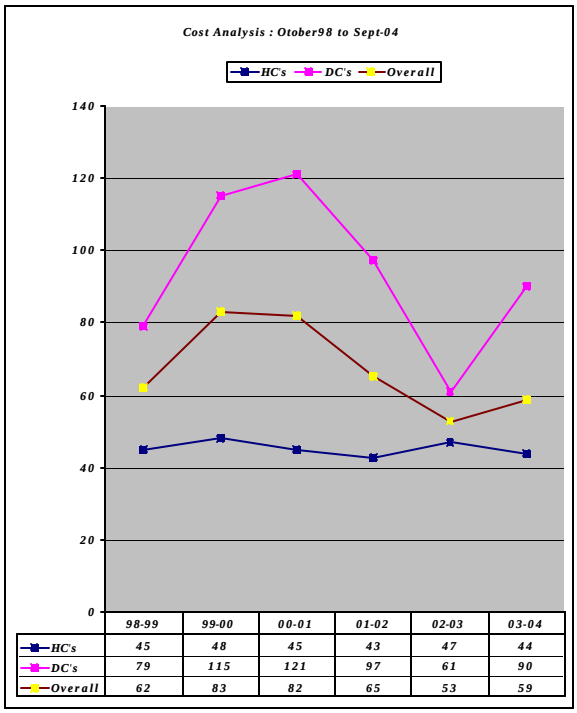
AHF has proved viable primarily in Patan district due to the higher socio-economic status of the beneficiary population in the area, and strong foundation of community support for the work of AKHS,I. As an example of the successes of AHF, the Meloj and Methan dairy co-operatives in Sidhpur have consistently contributed INR 30,000 and 15,000 towards covering operations costs incurred at the health centers in their villages. This is done by the deduction in price of a few mere *paise* (cents) from each liter of milk sold. The resultant funds are vast sums of money for villagers to be generating and allocating for the health care of their families and communities, a fact which demonstrates AKHS,I success in imparting the long-term value of health care upon members of the dairy co-operatives. On the other hand, the pre-paid family insurance scheme has witnessed ever-decreasing levels of participation, reflecting the fact that, as common elsewhere in the developing world, families are not motivated to insure themselves when they do not foresee illness as being a major risk.

C. Increase utilization and operational self-sufficiency for the network of facilities

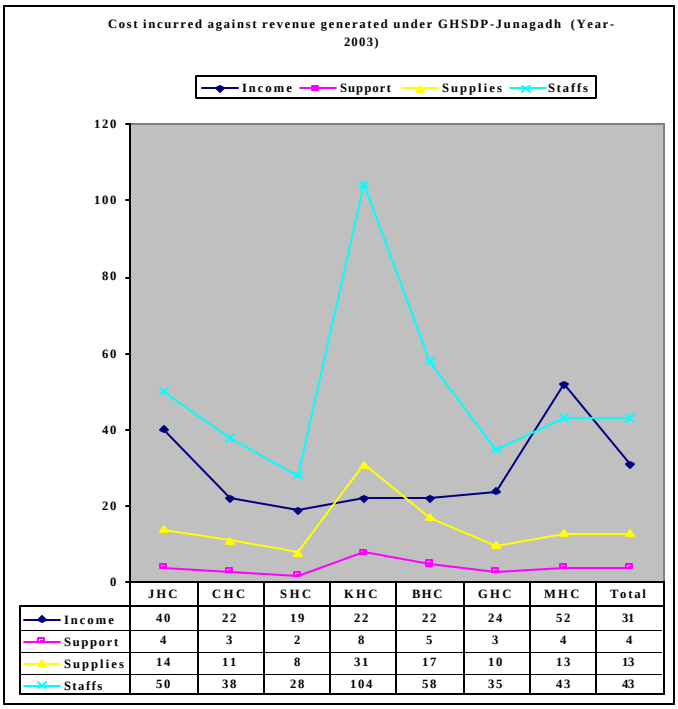
Recognizing that revenue from health centers would not be sufficient to cover all costs, the Project promoted a cross-subsidization model whereby revenues from diagnostic centers were used to off-set health center operating costs. Cross-subsidization was seen as an effective strategy in this regard as diagnostic center revenues were generally much higher than their expenditure, the opposite of which was true for health centers. This model proved very

effective, particularly during 2000-2001 period, but less successful in latter years due to decreased utilization of diagnostic centers attributed to high attrition of specialists and growing provider competition

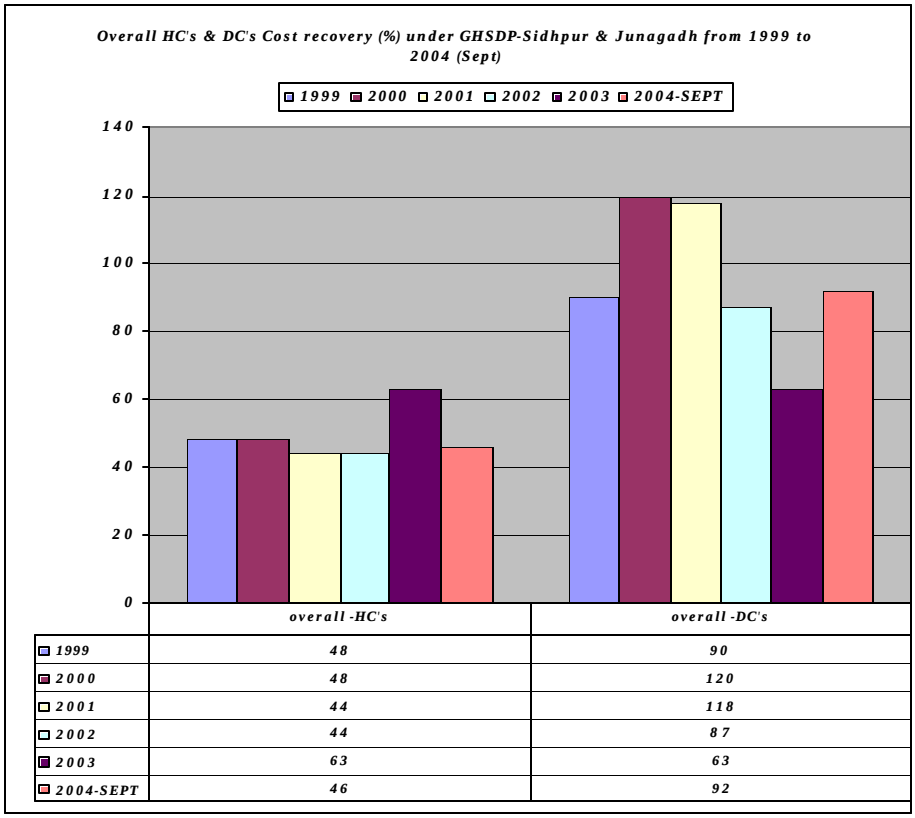
The attached graph illustrates cost recovery trends over the life of the project and average rates for health and diagnostic centers



	98-99	99-00	00-01	01-02	02-03	03-04
HC's	45	48	45	43	47	44
DC's	79	115	121	97	61	90
Overall	62	83	82	65	53	59



	JHC	CHC	SHC	KHC	BHC	GHC	MHC	Total
Income	40	22	19	22	22	24	52	31
Support	4	3	2	8	5	3	4	4
Supplies	14	11	8	31	17	10	13	13
Staffs	50	38	28	104	58	35	43	43



	overall -HC's	overall -DC's
1999	48	90
2000	48	120
2001	44	118
2002	44	87
2003	63	63
2004-SEPT	46	92

Several strategies designed to increase utilization of both health and diagnostic centers were employed over the course of the Project period, i.e. social marketing of services, sensitization to long-term benefits of health care, development of discounted diagnostic service packages, direct marketing to clients, etc. However, these strategies increased utilization rates sporadically and unevenly across facilities, and were hindered by high staff turnover at all levels (See Annex 19 for utilization rates across facilities since project inception). In addition, operating as a private provider in a highly competitive and unregulated market, while maintaining quality and incorporating non-revenue generating services, has affected the overall financial sustainability of the Project.

Objective 4: Documentation and sharing of project outputs, best practices and lessons learned with key stakeholders (communities, government, AKF, USAID, NGOs, private sector providers)

Consolidation of project experiences and sharing of information has historically been the project's weakest link. AKF India created a framework for documenting progress and lessons learned only in June 2004, the final year of the Project. The Final Evaluation team brought attention to this issue in its report, whereby it recommended that a comprehensive process-documentation workplan be devised shortly after Project inception.

A. Form project review committee with stakeholder representation

The Project was however successful in institutionalizing quarterly Project Review Committees, which regularly occurred throughout 2003-2004, and resulted in streamlined planning and improved monitoring.

B. Form a core group to documentation activities, impacts and lessons learned

At the time of the no-cost extension, it was planned that project staff would create a comprehensive lessons learned document in the 15-month period, but progress on this front experienced numerous delays. Low outputs in this area can be attributed to insufficient human resources and internal capacity, which halted the formation of a core team dedicated to documentation. Though resources were allocated for Training and Documentation Officers, this position was plagued by high staff attrition, and greater emphasis was paid to fulfilling internal training requirements. Consolidation of lessons learned commenced only in January 2004, with the hiring of qualified full-time professional devoted primarily to this task.

C. Organize and participate in workshops and seminars on community health

A presentation on the Project's child survival activities was made to the American Public Health Association in 1999 by the then AKF India Project Manager. In 2001, a presentation of the project's overall achievements in health status was subsequently delivered to the Global Health Council by the then Project Co-coordinator for Patan district.

D. Carry out surveys and case studies on a variety of pertinent subjects

In 2003, AKF India developed a two-paged offset Project brief for internal and external distribution to targeted audiences, and in 2004, completed a five-part series of qualitative testimonials of community health workers and volunteers entitled VOICES. These documents tell the stories of women and men who, inspired by the values and mission of AKHS,I,

dedicated years of their lives to improving the health status of their own communities. The VOICES series has been circulated to other AKF country units, and will be more widely shared both within and outside of India to bring attention to the indispensable role community health workers and volunteers play in project implementation. As part of the documentation framework, a paper summarizing the implementation strategy and outcomes of the replication model has been drafted, with a similar paper on the facilitation model to be completed by Project end.

Funds secured in 2004 through the AKF USA-managed Monitoring, Management and Institutional Learning (MMIL) component of MG V were used to conduct a quantitative End-of-Project Survey and produce a paper capturing project experiences in cost-recovery.

IV. MONTIORING AND EVALUATION

Baseline Survey (2000)

One component of Objective 1 was expansion of the project to additional villages and an increase in the beneficiary base by 15,000. Prior to expansion, the project team deemed it necessary to conduct a baseline survey as little or no data was available on either existing or new added villages.

The Department of Community Medicine of the Mahatma Gandhi Institute of Medical Sciences (MGIMS) was selected as the appropriate agency to conduct the baseline as a previous study done by another agency was not felt to be sound. The baseline was conducted in May–June 2000 and provided data comparing the existing Project villages to the newly added villages. However, AKHS,I exercised caution in using the data as for some variables, coverage rates in the newly added villages were better that rates in the existing Project villages where AKHS,I had been active for several years. A repeat baseline was not conduced as the project was planning to institute a new monitoring system in the coming months.

Mid-Term Review (2001)

In addition to the internal review held by AKHS,I in September 2000, an external Mid-Term Review was conducted in September 2001. The overall assessment of the project was positive, with particular praise given to the wide degree of service coverage, high cost-recovery rates achieved across the network of facilities and unique potential of the facilitation model to create long-term health benefits using cost-effective methods and local resources. However, attention was drawn to the fact that in light of the revised goal, objectives and DIP, a clear strategy ought to have be devised to provide an expanded set of quality essential RCH services while simultaneously contributing towards financial sustainability of facilities. The Mid-Term Review team concluded that the expanded package of health services needed to be more focused on the actual health needs of the beneficiary population, BCC strategies would best be tailored for a particular set of key interventions, and that more effort was required in consolidating lessons learned and documenting best practices.

Management Information System (2002)

The project's initially outdated and burdensome MIS system was carried over from SJHSP, and was later streamlined, digitized and customized to fit project requirements. This called for the hiring of additional field staff and training in use of the software package, which was made compatible to SPSS for easier access to and analysis of data. Using the customized MIS, the Project conducted a household enumeration exercise in all 55 Project villages in order to ascertain the demographics of the target population. The survey enabled profiling of the socio-economic and health information of the project's primary beneficiary groups, i.e. children under three and women of reproductive age and provided the first set of data on performance in key areas such as ANC/PNC, immunization, contraceptive coverage, malnutrition, etc. (Report available under separate cover).

Findings from the Final Evaluation revealed that data collection and analysis should be more aligned to the Project's objectives, and to changes in objectives as and when they occur. Distinction between the type of data required for program management purposes and assessment of health status should be more clearly reflected in the Project's MIS. Furthermore, staff capacity in making log frames operational must be strengthened. While LHVs felt that registers and formats had greatly improved by Project end, it was suggested that the household register be used as a census tool on a yearly basis to alleviate the burden of having to update records each month.

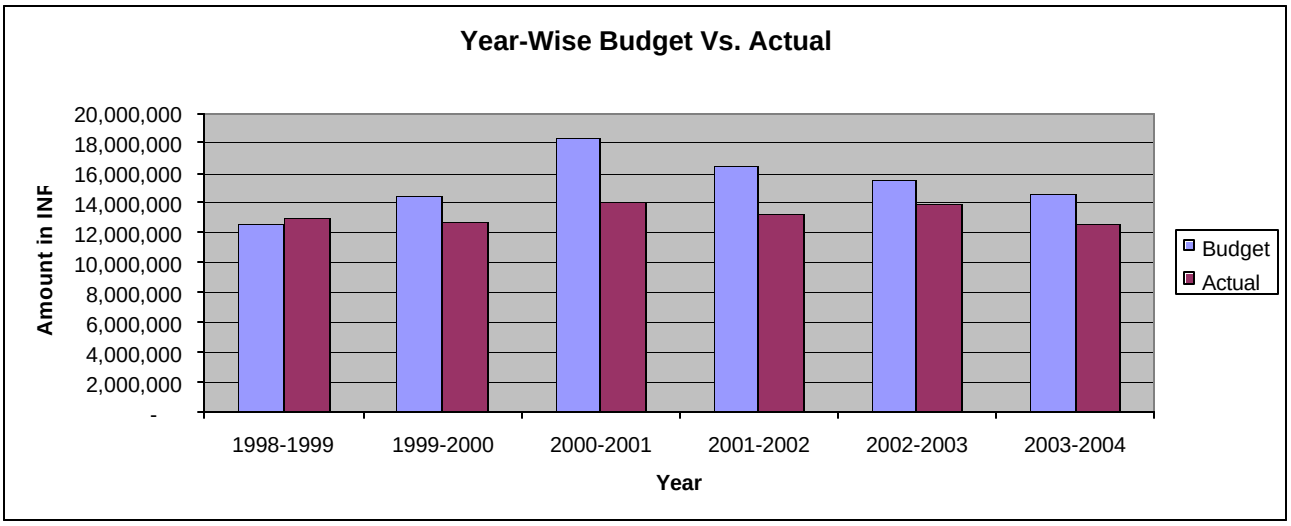
End-of-Project Survey

The Center for Operations Research and Training (CORT) conducted a quantitative end-of-project survey in all villages in the project area. As one component of the Final Evaluation, the End-of-Project Survey provided estimates to enable an understanding of the extent to which the Project has been able to achieve its goal. The survey was designed to generate data (both knowledge and practice) on a range of RCH indicators as well as the health seeking behaviors and utilization of AKHS,I services among beneficiaries. As there is was no reliable baseline data, the results of the survey were compared to indicators collected at the state and district level through the 2001 census and the National Family Health Survey II (1998-1999). (See End-of Project Survey report under separate cover).

Final Evaluation

A Final Evaluation of the Project was conducted in October – November 2004. The evaluation team comprised of two external evaluators and looked at overall progress against objectives and key impacts in light of the recommendations made by the Mid-Term Review team in 2001.

V. FINANCIAL MANAGEMENT



VI. CHALLENGES

1. Striking a balance between affordable community-based health care and financial sustainability of the network of facilities proved a significant challenge. The reality is that providing preventive and promotive services has long-term health benefits but contribute very little to cost-recovery, whereas providing curative services through user fees generates substantial funds, but only address minor health issues which will continue to recur indefinitely.

2. Retaining clinical staff has proven to be a serious obstacle, particularly at the field level as MOs are generally posted in rural areas for short periods of time before establishing their own practices, and LHVs continue to leave for the more attractive remuneration packages offered by the Government. This discontinuity not only decreases utilization of health and diagnostic centers, thereby reducing revenue, but also places undue strain on core Project staff who have to continually orient and re-train new hires.

3. Mobilizing the marginalized segments of society, i.e. women, minority ethnic groups, etc. has not resulted in high levels of participation among these groups, particularly where HSMCs/VLCs are concerned. While inroads have been made in this regard in certain villages, ethnic divisions and exclusion of women remains the norm. In order to foster genuine community involvement, ownership and lasting health gains, more attention must be paid to devising strategies to reverse this trend.

4. Identification and solicited involvement of quality public and private health care providers active within the project area has not occurred at the desired pace, which poses particular problems for the facilitation model in Junagadh District. Oftentimes, these providers do not see sufficient benefits in making alliances with AKHS,I, and view networking efforts as counter to their own interest in maintaining their market share.

5. Maintaining the interest and involvement of CHVs in conducting their preventive and promotive activities at the household level without remuneration has become increasingly difficult as more and more responsibilities have been transferred to these volunteers given the overburdened workloads of LHVs. Experiences suggest that offering a nominal honorarium to CHVs may positively affect their levels and quality of performance.

VII. LESSONS LEARNED

1. Quality and continuity of services are important for sustaining the community's interest, ensuring their participation and increasing utilization of health and diagnostic centers.

2. Complete recovery of costs solely through levying user fees is not a realistic expectation of a community-based health project. Cross-subsidization of health center costs by diagnostic center revenues, however, can play an important role in off-setting operational costs, thereby contributing to higher levels of financial sustainability for the overall system.

3. High staff turn over hinders the regular cycle of program implementation, therefore concrete efforts must be taken towards retention of qualified staff at all levels.

4. BCC activities should ideally be very specific, rooted in the predominant practices of each village and relate to interventions key in brining about long-term health gains.

5. Regular trainings and continuous motivational effort have shown positive response in the *facilitation* villages of Junagadh District. Intensive BCC and awareness campaigns have been successful in empowering the community to adopt healthful living habits and collective responsibility for cleanliness drives, banning tobacco and implementing disease control measures.

6. Representative participation of both men and women across all ethnic groups in Project villages is a prerequisite for acceptability and sustainability of health programs. A diverse Health Sector Management Committee/Village Level Committee is an indispensable asset for ensuring a sense of community ownership and success of community health programs.

7. Continuous and positive interaction between beneficiaries and health workers is required for long-term relationship and rapport building with the community.

8. Proper leadership, guidance and supportive supervision is needed to foster a spirit of teamwork at the field level, without which progress is not possible at the desired pace.

9. Planned involvement of communities in the management of health centers and marketing of services can have a positive impact on utilization of services and operational sustainability overall.

10. Communities need to see the tangible results of their efforts if their support and involvement in activities is to be long-term. Efforts to build rapport and mobilize communities must incorporate this principle to maximize benefits.

11. Focused community participation, target setting, micro-planning, supportive supervision, continuing education, collaboration with the government, decentralized management and effective use of MIS have all had definite positive impacts on the project and should be further strengthened in follow-on projects.

VIII. CONCLUSION

Considerable achievements have been made under GHSDP, which warrant notice both within and outside the AKDN to further build institutional expertise in community-based primary health care programs. Through experiences gained during this six-year project, AKHS,I has been able to develop key strengths in cost-recovery and financial sustainability, community empowerment and promotion of healthy behaviors. Areas that remain in need of improvement are human resource management, management information systems and documentation. Given the significant improvements in health status among direct beneficiaries, AKHS,I would do well to leverage their reputation as a quality service provider, build upon momentum achieved under GHSDP and expand areas of intervention. This would entail internal reflection upon the results of the End-of-Project Survey and Final Evaluation to consolidate lessons learned and best practices to inform AKHS, I's future strategy and design of follow-on projects.

IX. FUTURE STRATEGY

AKHS,I is currently reviewing its entire community health program, including GHDSP, to determine which projects ought to be continued in their present form, modified significantly, scaled down and/or terminated. The organization is at a critical time of transition where there is much reflection concerning its appropriate role(s), technical foci, geographic loci, etc. It is clear that more work needs to be done in the less developed district of Junagadh, on a scale perhaps double in size as that of GHSDP.

In building upon progress made under GHSDP, AKHS,I will refine its areas of intervention to reflect recent demographic shifts in its beneficiary population. Such trends show that the needs of adolescents, young adults and geriatrics will become paramount in the coming years. As a result, AKHS,I plans to expand its traditional area of RCH service delivery to address issues such as HIV/AIDS and non-communicable diseases, thereby spanning the entire life cycle. Expansion to the states of Maharashtra and Andhra Pradesh are also a possibility, given the need to focus more attention on health issues in peri-urban areas. Cross-cutting concerns will remain to be gender equity, quality assurance, alternative health financing, community empowerment and partnerships with public and private health care providers (See Annex 22 for AKHS,I future health strategy).

Annex 1
Mandate of Aga Khan Health Service, India

Mission

To provide access to comprehensive high quality health care and promote physical, social and mental well being in the target population through establishment of a sustainable health care system and based upon the principles of volunteerism, professionalism and community participation.

Vision

To be an innovative, credible, cost-effective organization specializing in community health; an organization that is responsive to the needs of underprivileged segments of society, empowers all communities and is supported by strong referral linkages and health systems design.

Role

To empower communities to access comprehensive high quality health care through both service delivery and facilitation of public and private partnerships. The focus will be on testing replicable models of health service delivery for specific interventions including HIV/AIDS and non-communicable diseases. An operations research approach will be utilized that enables measurement and scientific documentation in addition to capturing the challenges, progress and impact of health care delivery systems.

Annex 2
Maps of the Project Area

Gujarat State, India

Patan and Banaskantha Districts

Junagadh District

Annex 3
List of Project Villages

* = Diagnostic Center Site

District	Taluka	Village Code	Village	Population	Number of Households
Project Villages with Health Center					
Patan	Sidhpur	601	Manpura	1206	252
Patan	Sidhpur	602	Methan	2687	570
Patan	Sidhpur	604	Vershila	1059	233
Patan	Sidhpur	603	Samoda	2433	490
Patan	Sidhpur	605	Meloj	3407	655
Patan	Sidhpur	610	Metrana	3114	504
Patan	Sidhpur	622	Wadhana	3249	605
Patan	Sidhpur	623	Vaghrol	2290	459
Project Villages without Health Center					
Patan	Sidhpur	606	Mundana	2193	384
Patan	Sidhpur	607	Ladjipura	204	44
Patan	Sidhpur	608	Meta	5584	1173
Patan	Sidhpur	609	Mahendipura	627	128
Patan	Sidhpur	611	Kunvara	4394	801
Patan	Sidhpur	612	Punasan	1122	222
Patan	Sidhpur	613	Vanasan	1148	219
Patan	Sidhpur	614	Ismailpura	134	31
Patan	Sidhpur	615	Kayan	505	92
Patan	Sidhpur	616	Lodhpur	407	84
Patan	Sidhpur	617	Deodarpura	981	200
Patan	Sidhpur	618	Sidhpur*	744	179
Patan	Sidhpur	619	Dethali	3315	632
Patan	Sidhpur	620	Alipur	297	51
Patan	Sidhpur	621	Abadpura	178	37
Patan	Sidhpur	624	Pachakwada	1234	268
Sub-Total				**42, 512**	**8, 313**

District	Taluka	Village Code	Village	Population	Number of Households
Project Villages with Health Center					
Junagadh	Keshod	701	Jonpur	1199	214
Junagadh	Keshod	706	Badodar	2192	442
Junagadh	Malia	713	Maliya*	741	183
Junagadh	Malia	717	Gangecha	1137	246
Junagadh	Talala	719	Chitravad	3096	622
Junagadh	Talala	721	Sangodra	1322	250
Junagadh	Mendarda	723	Kenedipur	1021	212
Project Villages without Health Center					
Junagadh	Keshod	702	Mangalpur	1417	256
Junagadh	Keshod	703	Muliasa	1070	174
Junagadh	Keshod	704	Madhada	750	138
Junagadh	Keshod	705	Paswariya	392	70
Junagadh	Keshod	707	Fagri	1263	213
Junagadh	Keshod	708	Keshod*	523	113
Junagadh	Keshod	709	Meshwan	64	12
Junagadh	Keshod	710	Agatrai	72	15
Junagadh	Vanthli	711	Akha	1919	308
Junagadh	Vanthli	712	Handla	1247	231
Junagadh	Malia	714	Shergadh	124	30
Junagadh	Malia	715	Avania	2127	399
Junagadh	Malia	716	Amrapur	3225	637
Junagadh	Talala	720	Haripur	1747	333
Junagadh	Talala	722	Virpur	1933	328
Junagadh	Talala	724	Bhalchel	1358	296
Junagadh	Mendarda	725	Khodiyar	1714	348
Junagadh	Mangrol	718	Lathodra	1820	343
Junagadh	Mangrol	726	Virdi	1761	332
Junagadh	Mangrol	727	Matarvani	1574	310
Junagadh	Mangrol	728	Bodi	854	161
Junagadh	Mangrol	729	Jalandhar	1507	241
Junagadh	Mangrol	730	Katrasa	1279	236
Junagadh	Mangrol	731	Devgam	1299	129
Sub-Total				**41, 747**	**7, 822**
Grand Total				**84,260**	**16,135**

Annex 4
Revised Detailed Implementation Plan

Objective 1 Enhance the quality and extend the range of diagnostic and essential health services in the existing program areas and expand coverage to an additional 15,000 residents

	Sub Objectives	Till Dec 2002	Till Mar 2003	Till Jun 2003	Till Sep 2003	Till Dec 2003	Till Mar 2004	Till Jun 2004	Till Sep 2004	Till Dec 2004
1.1	**Ensure Uniform package of EHS for the target population by March 2004**									
	a. Building capacities of personnel	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
	b. Create Infrastructure	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
	c. Ensure implementation	XXX	XXX	XXX	XXX	XXX	XXX			
1.2	**To improve overall quality of EHS by March 2004**									
1.2.1	**Technical Quality**									
	a. Ensure that all the protocols are available for reference in the local language.	XXX	XXX	XXX						
	b. Ensure that all the professionals are well trained in protocols for EHS	XXX	XXX	XXX	XXX	XXX				
	c. Develop/Field test and finalize quality assurance checklist for EHS.			XXX	XXX	XXX	XXX	XXX	XXX	
	d. Ensure that all the staff are trained in QA.					XXX	XXX	XXX	XXX	
	e. Ensure standard operating procedures in place.(Manual, training, implementation)	XXX	XXX	XXX	XXX					
1.2.2	**Skills & competence dev. of personnel**									
	a. Develop training modules on:									
	Program Protocols	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
	QA Check lists		XXX	XXX	XXX	XXX				
	Standard Operating Procedures				XXX	XXX	XXX	XXX		
	b. Trainings to staff/volunteers to ensure minimum standards		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
1.2.3	**Physical Infrastructure**									

	a. Establish standard waste disposal system in all health centers	XXX	XXX	XXX	XXX					
	b. Ensure standard package of equipments and facilities	XXX	XXX	XXX	XXX	XXX				
	c. Improve system of maintenance of equipments, facilities	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
	d. Strengthen monitoring system	XXX	XXX	XXX	XXX	XXX				
1.3	**Extension of EHS package to additional 15000 population**									
	Junagadh									
	a. Revise the list of quality care providers	XXX	XXX	XXX	XXX	XXX				
	b. Rapport with Public Private Providers(PPP)	XXX	XXX	XXX	XXX	XXX				
	c. Conduct study on health seeking behavior	XXX	XXX	XXX	XXX					
	d. Capacity building trainings for private providers, traditional Birth attendants, AWWs, ISM practitioners	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
	e. Implementation plan	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
	f. Identify & develop future trainers	XXX	XXX	XXX						
	g. Strengthen supervision & monitoring system	XXX	XXX	xxx	xxx	xxx	XXX	XXX	XXX	XXX
	h. Evolve an Exit strategy with the help of the community		XXX	XXX	XXX	XXX	XXX			
	I. Formation of apex body with representation of PPP, Community & AKHS,I			XXX	XXX	XXX	XXX	XXX	XXX	
	j. Develop service delivery mechanism				XXX	XXX	XXX	XXX	XXX	
	k. Establish referral systems		XXX	XXX	XXX	XXX	XXX	XXX	XXX	
	l. Preparation & signing of MOU		XXX							
	Sidhpur									
	a. Strengthen Management & monitoring mechanisms	XXX	XXX	XXX	XXX	XXX	XXX			
	b. Training of village health committee members	XXX	XXX	XXX	XXX	XXX	XXX			
	c. Identify & develop members who could be trainers and take leadership for all the activities of the project			XXX	XXX	XXX	XXX			
	d. Develop/evolve an exit strategy	XXX	XXX	XXX						
	e. Community Empowerment	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
1.4	**Enhance range and quality of DC services by mid 2003**									
	a. Assess present quality / range of services provided / Identify gaps	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
	b. Do feasibility for adding new services - ELIZA, Serum Electrolytes, Histopathology/HIV/HepB	XXX	XXX	XXX	XXX					

	c. Add/initiate new services	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
	d. Capacity building/trainings	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
	e. Develop/field test quality assurance check lists/SOPs for DC	XXX	XXX	XXX	XXX					
	f. IT network - connect DC with PAKH.	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
1.5	**Expand range of services to include STI/RTI/HIV/AIDS awareness**									
	A. In existing areas.									
	a. Capacity building/trainings	XXX	XXX	XXX	XXX					
	b. Develop MIS, Supervision/ Monitoring system	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
	c. Develop/Field test/Finalize protocols/IEC guidelines	XXX	XXX	XXX	XXX					
	d. Develop service delivery mechanisms (prevention/Diagnosis/ treatment for RTI/STI/HIV		XXX	XXX	XXX					
	e. Pilot test FLE in 4 centers		XXX	XXX	XXX	XXX	XXX			
	f. Document experiences/make revisions				XXX	XXX	XXX	XXX		
	g. Replicate in all existing sectors					XXX	XXX	XXX	XXX	
	B. In New areas.									
	a. Capacity building/trainings			XXX	XXX	XXX	XXX			
	b. Develop MIS, Supervision/ Monitoring system			XXX	XXX	XXX	XXX			
	c. Develop service delivery mechanisms (prevention/Diagnosis/ treatment for RTI/STI/HIV				XXX	XXX	XXX			
	d. Initiate implementation.				XXX	XXX	XXX	XXX	XXX	
1.6	**Develop IEC Strategy**									
	a. Undertake communication need assessment	XXX								
	b. Develop core team for carrying IEC activities	XXX	XXX	XXX						
	c. Develop IEC packages	XXX	XXX	XXX						
	d. Explore possibilities for marketing the IEC developed capacities	XXX	XXX	XXX		XXX	XXX	XXX		
	OBJECTIVE 2. Enhance the organizational effectiveness by introducing comprehensive systems for human resource development, management and finance									
2.1	**Introducing comprehensive HRM system**									
	a. Organizational review	XXX								
	b. Compensation review	XXX								
	c. Appraisal system	XXX								
	d. Comprehensive audit of HRM in AKHSI	XXX								
	e. Review & revise HR policy	XXX	XXX	XXX						

	f. Prepare HR plans		XXX	XXX						
	g. Analyze/develop role-task skill list		XXX	XXX	XXX					
	h. Review & revise JDs	XXX	XXX	XXX	XXX	XXX				
	I. Identify/recruit required staff	XXX	XXX	XXX	XXX	XXX	XXX	XXX	xxx	xxx
	j. Establish performance management system	XXX	XXX							
2.2	**Establish & operationalize HPDC by September 2003**									
	a. Develop strategies for HPDC utilization	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
	b. Develop marketing strategies for HPDC	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
	c. Organize training program at HPDC									
	d. Develop networking with Govt, NGO, AKDN institutions									
2.3	**Capacity building of staff & volunteers**									
	a.TNA for all levels	XXX		XXX				XXX		
	b. Strengthen the core team for future programs Mental health, Gender in RCH, HIV/AIDS	XXX		XXX				XXX		
	c. Continue to develop need based training packages	XXX		XXX		XXX		XXX		
	d. Conduct prioritized training	XXX								
	e. Develop MIS system for effective training & follow up of training activities		XXX	XXX	XXX	XXX				
	f. Measure effectiveness of trainings		XXX	XXX	XXX			XXX		
2.4	**Develop IEC strategies to address the emerging program needs**									
	a. Review baseline for KABP of communities			XXX						
	b. IEC needs assessment			XXX						
	c. Develop packages for IEC	XXX	XXX							
	d. Develop Core teams	XXX	XXX	XXX						
	e. Consolidate the activities to develop IEC resource center	XXX	XXX	XXX	XXX		XXX			
	f. Market IEC services	XXX	XXX	XXX	XXX	XXX				
2.5	**To Improve the Management systems.**									
	a. Strengthen/establish Health Management Information System	XXX	XXX	XXX	XXX	XXX				
	b. Strengthen/establish logistics system	XXX	XXX							
	c. Institutionalizing program review meeting (quarterly)	X	X	X	X	X	X	X	X	X

	d. Strengthen program planning/supervision/ monitoring in field	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
	e. Capacity building		XXX							
2.6	**To improve finance**									
	a. Institutionalize & monitor use of activity based budget	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
	b. Train staff & volunteers			XXX	XXX	XXX	XXX			
	c. Implement activity based reporting with narrative reports	XXX	XXX	XXX	XXX	XXX	XXX			
	d. Periodical review and follow up		XXX		XXX		XXX		XXX	
	e. Institute a system of maintaining self-sustainability analysis at each facility level.	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX

Objective 3: Improve financial sustainability of network of facilities in the project area

3.1	**Take over of at least 4 old HCs by the community by the end of the Project**									
	a. Signing of Memorandum of understanding between AKHS,I and the Community representatives			XXX	XXX					
	b. Training of the community especially vis-à-vis. Finance, Inventory Management, Day to day administration & personnel management.	XXX	XXX	XXX	XXX	XXX	XXX			
	c. Phase wise take over									
	1. Inventory management		XXX	XXX						
	2. Day to day administration		XXX	XXX						
	3. Finance Management			XXX	XXX					
	4. Personnel Management				XXX	XXX				
	5. Marketing of Services	XXX	XXX			XXX	XXX		XXX	
	6. IEC session with the community	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
	d. Regular monitoring & evaluation of programs	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
	e. Ensure the quality of programs through on going refresher trainings		XXX		XXX		XXX		XXX	XXX
3.2	**AHF mechanisms developed and introduced in at least two additional facilities.**									
	a. Study the various AHF mechanism	XXX	XXX	XXX	XXX					

	b. Pilot test and adopt AHF mechanisms for two additional villages	XXX	XXX	XXX	XXX					
	c. Review on regular basis		XXX		XXX		XXX		XXX	
3.3	**Increase the utilization & operational self-sufficiency for the network of health facilities in Gujarat by 10% at the end of 2003 and 15% by Dec 2004.**									
	a. Social Marketing of HC & DC services ongoing	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
	b. Develop package of services for HC & DC	XXX	XXX							
	c. Sensitization on initial cost saving mechanism	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
3.4	**Close Amrapur Health Center**									
	a. Initiate dialogue with HC community	XXX								
	b. Strengthen the HSMC for taking up facilitator role through trainings	XXX								
	c. Network with PPP for service	XXX								
	d. Close HC (Only Curative Service)		XXX							
	e. Take up facilitators role & continue with prevention & promotive services	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX

Objective 4 Documentation and share project outputs, outcomes, best practices and lessons learned with key stakeholders (communities, government, AKF/USAID, AKDN institutions, NGOs, Private sector providers)

a.	Formation of PRC & advisory committee with representation of stakeholders	XXX	XXX	XXX						
b.	Form a core group for monitoring all the documentation activities of the project.	XXX	XXX							
c.	Organize & participate in Workshops / Seminars /review meeting	X	X	X	X	X	X	X	X	
d.	Carry out special studies & case studies on									
	1. AHF				XXX	XXX				
	2. New Villages especially focusing on community mobilization & organization, PPP, SHG, etc			XXX			XXX			
	3. TOT and Counseling skill training	XXX								

Annex 5
Rationales for Revised Objectives

Sr. No	Original Objectives	Revised Objectives	Rationale for Revision or Deletion
1.	Improve access to basic health services for an additional 15,000 residents, thus serving a total population of 86,000	**Objective 1:** Enhance the quality and extend the range of diagnostic and essential health services in the existing project area and exp and coverage to an additional 15,000 residents	Going beyond the final evaluation recommendation made under MG IV to implement activities in additional villages, the project team decided it necessary to broaden the package of essential health services to include prevention, diagnosis and treatment of Reproductive Tract and Sexually Transmitted Infections (RTI/STI) and prevention of HIV/AIDS. Gender sensitivity and mental health were also included as priority areas for intervention. Beyond merely extending the range of services offered, greater emphasis was placed on quality assurance in keeping with AKHS,I core values and given increased competition from the growing number of other private providers in the project area.
2.	Provide diagnostic and maternity care by establishing two maternity homes with polyclinics and blood banks in locations identified through a feasibility study	None – deleted	Construction of a Maternity Home in Junagadh was stopped after a feasibility study conducted in 1999 concluded the undertaking to be financially unviable and inappropriate in a market already saturated with private providers offering similar services. The Sidhpur Maternity Home was also dropped, despite being deemed financially sustainable, due to lack of community willingness to donate land for construction of the home.
3.	Enhance institutional capacity and program sustainability by improving internal planning, monitoring systems and human resource management capacity, and establishing a Health Professional Development Center (HPDC) to train staff and volunteers from AKHS,I, local NGOs and government	**Objective 2**: Enhance the organizational effectiveness of AKHS,I by introducing comprehensive systems for human resource development, management and finance	No revisions were made to this objective – the language was merely refined for greater clarity.

Sr. No	Original Objectives	Revised Objectives	Rationale for Revision or Deletion
4.	Strengthen and consolidate community development initiatives by enhancing the capacity of communities to mange at least two health centers	None – deleted	As per the revised Detailed Implementation Plan (DIP), this objective became Sub-Objective 3.1: Take over of at least 4 old health centers by the community by project end.
5.	Implement Alternative Health Financing (AHF) mechanisms in half of project villages and achieve 90% operational self-sufficiency of the overall system	**Objectives 3**: Increase the financial sustainability of the network of AKHS,I facilities in the project area	Given the high amount of inputs required to develop AHF mechanisms at the village level, the project team scaled down the number of villages to 2 – Methan and Meloj in Sidhpur area of Patan district – as these villages possessed the financial capacity and willingness to participate in AHF schemes. Based on cost recovery experience under MG IV, 90% operational sustainability was deemed a very un-realistic target as costs were ever increasing and rates of recovery depended upon fluctuations in utilization of health and diagnostic centers, which in turn were dependent upon several other factors such as willingness and ability to pay among beneficiaries and increased competition from private providers.
6.	Test initiatives that contribute to project sustainability, i.e., income-generation, improved household sanitation, social marketing and Information, Education and Communication (IEC)	None – deleted	Retaining this objective was thought impractical as it would divert attention from the goal of the project and place added pressure on an already over-stretched human resource capacity. However, social marketing and IEC components were incorporated in the revised DIP under Objective 2
7.	Document and share project experiences with government and other interested organizations	**Objective 4**: Document and share project outputs, outcomes, best practices and lessons learned with key stakeholders	This objective was not revised, but rather refined to place greater emphasis on documenting specific outputs and outcomes with targeted audiences.

Annex 6
List of Essential Health Services

#	Essential Health Services	Messages Developed	Materials Distributed	Protocols Developed
1	Ante, intra and postnatal care	√	√	√
2	Immunization (children and pregnant women)	√	√	√
3	Newborn Care	√		
4	Growth and Development Monitoring	√	√	√
5	Family Life Education	√	√	√
6	Adolescent Health	√	√	√
7	Family Planning	√	√	√
8	Reproductive and Sexually Transmitted Infections	√	√	√
9	HIV/AIDS Awareness	√	√	√
10	Gender	√	√	√
11	Acute Respiratory Infection	√	√	√
12	Tuberculosis	√	√	√
13	Diarrheal Diseases	√	√	√
14	Malaria	√	√	√
15	Hypertension	√	√	√
16	Coronary Heart Disease	√	√	√
17	Diabetes	√	√	√
18	Cancer	√	√	√
19	Obesity	√	√	√

Annex 7
Progress against Mid-Term Review Recommendations

Recommendation #1: *To determine the effectiveness of GHSDP, AKHS,I should randomly select three health centers in each project site and conduct a thorough review of the service records to: enumerate the entire population to be served by those centers; ascertain who is being served (i.e. the denominators) and to determine the level of performance in such key areas as immunization, ORS use, contraceptive usage, LBW, malnutrition rates*.

- This was done in 2002 initially for 6 villages – 3 each in Junagadh and Patan Districts, and was followed by a full-fledged house-to-house survey for all 55 project villages. The survey has enabled profiling of the socio-economic and health information of the project's primary beneficiary groups, i.e. children under three and women of reproductive age. Results of the survey show that 83,713 people in the project area are currently being reached. Performance indicators for the project's primary interventions are given in Table 1 below.

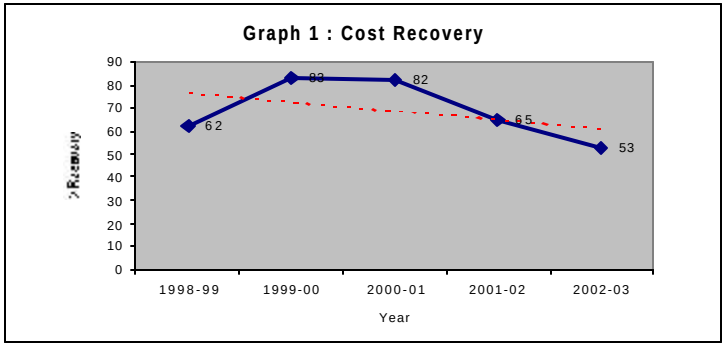
Table 1: GHSDP Performance to Date (January 2004)

Indicator	GHSDP (%)	National Health and Family Survey, Gujarat (1998-1999) %	National Health and Family Survey, India (1998-1999) %
ANC Registered in First Trimester	63	36	33
Institutional Delivery	56	33	34
Three Post Natal Check-ups	51	13	N/A
Hemoglobin < 10gm. (Women 15-49 years)	31	47	52
Breastfed within 2 hours of birth	41	10	16*
Immunization (Children 0-1 years)	78	53	42
Malnutrition (Grade 3)	1	16	18
Use of any Family Planning Method	77	57	48

Recommendation #2: *AKHS,I should carefully define the balance between a focus on interventions that will directly impact the health status of the under-three population and women of reproductive age and those that contribute to the objective of financial self-sufficiency. It is acknowledged than an exclusive focus on child and reproductive health services may generate lower revenues,*

requiring more resources from outside AKHS,I e.g. international donor agencies. It is, however, important to determine the balance between the objectives to estimate the amount that will be needed to cover the shortfall.

- In addition to 15 health centers, which offer curative care, AKHS,I operates 2 diagnostic centers, the revenue of which is used to cross-subsidize the costs incurred by the health centers. Due to staff attrition and increase competition, the overall cost recovery rate for both types of centers has markedly decreased from 82% in 2001 to 54% in 2003.



- Attention is currently being paid to utilization rates at the health centers, a component of which entails educating the community at large as well as public and private providers on the long-term health benefits gained by using the preventive and promotive services offered at the health centers.
- Marketing strategies for increasing patient load are also being devised for future implementation though much work remains to be done.
- Currently, the health centers recover an average of 46% of their costs, while diagnostic centers 63%. Linkages with corporate businesses, dairy co-operatives, etc. are being explored to bridge the shortfall and enhance long-term sustainability.

Recommendation #3: *AKHS,I should take steps to improve the working conditions in the organization. These steps should include: decentralized decision-making at the facility and community level; increased compensation for employees; and the provision of more opportunities for professional growth and skill enhancement. The CHVs may be asked to work closely with the social educators and community organizers rather than the LHV to mobilize the community and to provide health education.*

- Two external reviews have been conducted, one by Mercer Human Resource Consulting and the other by a post-graduate student in international health management and policy. A limited number of revisions have been put into place.
- Improved compensation packages were offered to AKHS,I employees, particularly at the LHV level. However, in 2003, the Board of AKHS,I instituted measures to reduce personnel-related overhead costs to improve cost-efficiency of the organization.
- In the case of two health centers, Health Sector Management Committees are already making decisions related to day-to-day administration. A strategy to hand-over more responsibilities to these committees has been articulated, but has not yet been acted upon. Similar principles will be applied to the remaining committees. In the course of decentralizing, AKHS,I has to be cautious to ensure that quality of care is not compromised. At present, total decentralization is not viewed as the desired end-goal.
- CHVs continue to work primarily with LHVs and report directly to LHV Supervisors, though they also work with *Anganwadi* Workers in monitoring the growth of children at the household level.

Recommendation #4*: The training officer should make a thorough study of the AKHS,I technical and managerial needs and establish priorities while identifying training programs in the country. In coordination with the Human Resources Manager, AKHS,I should develop a two-year training calendar that would respond to the priority training needs*.

- Capacity building trainings have been delivered since October 2002 to:
  - Executives and Senior Management on Performance Appraisal Techniques;
  - Program staff, field managers, field officers, and community organizers on Training of Trainers;
  - LHVs, LHV Supervisors, Community Organizers and Social Educators on Adolescent Health/ Family Life Education;
  - Traditional Birth Attendants on safe delivery practices in the six new villages in Junagadh District; and
  - CHVs and Anganwadi Workers on Infant Feeding and Childhood Nutrition for Effective Growth Monitoring

- A challenge with respect to capacity building has been high staff turnover at all levels.

Recommendation #5: *AKHS,I should undergo an organizational assessment to identify aspects in need of strengthening and adapt the tool(s) to determine the progress of villages toward managing their own health activities*.

- Mercer Human Resource Consulting conducted an organizational audit in 2003 and recommendations regarding improved human resource management are being implemented. Some initial attempts at describing the features Health Sector Management Committees ought to possess for effective administration of health centers have been made, but need greater attention.

Recommendation #6: *AKHS,I should articulate clearly its approaches to community health and the phases of operations in each model of assistance (e.g. fixed facility, facilitation, replication).*

- This recommendation was not fully agreed to as AKHS,I has a clearly articulated approach to community health. What was seen as more critical was the need to develop future strategic direction based on experience and demographic trends in the region.
- A series of meetings were held between AKF India and AKHS,I between 2003-2004 to develop internal thinking for AKHS,I's future strategy development, the results of which are being reviewed and considered by the governing Boards of both organizations.

Recommendation #7: *Those responsible for training, documentation and marketing should identify specific training areas (e.g. alternative health financing, community mobilization, private/public collaboration), appoint a task force of community health specialists, prepare training modules that take advantage of the practical training opportunities in HPDC, Jonpur that can be aggressively marketed.*

- An internal task force was appointed, but HPDC still remains under-utilized. AKHS,I has approached other agencies of the Aga Khan Development Network to utilize this center as a training resource across sectors.

Recommendation #8: *Communications and Behavioral Change efforts should be focused on priority interventions (see Recommendation #2). Appropriate materials that already exist should be adopted/adapted. Staff at all levels should be trained in their use and in counseling skills.*

- A set of 100 flashcards on reproductive and child health care (ante and post natal care, proper breastfeeding practices, STIs/HIV/AIDS, etc.) was developed and a training on their use delivered to LHVs and CHVs in September 2002.
- Posters illustrating the importance of immunization, antenatal check-ups and condom use have been procured from government sources and are on display in the health and diagnostic centers.
- Booklets in the local language on the topic of safe motherhood have been developed by AKHS,I.

Recommendation #9: *AKHS,I should review existing instruments (e.g. Health Facility Assessment) that have been developed and found useful in monitoring the quality of training and service delivery in community health programs in developing countries and adapt them to the AKHS,I program within the last several years of MG V.*

- No externally developed instruments have been utilized to this end, though a client satisfaction survey covering 10% of patients was conducted in 2003, the results of which can be made available upon request.

Recommendation #10: *The key managers and community organizers of AKHS,I should be trained in PRA or PLA and the new villages should be engaged in the process of identifying the specific health problems of the target population (under-three children and women of reproductive age) and proposing solutions.*

- A PRA and PLA exercise was conducted. Major findings were the high occurrence of non-communicable diseases such as diabetes, hypertension and cancer in the project area, as well as low awareness levels on maternal and child health in the six new villages.
- Subsequent to consolidation of findings, NCD screening camps are now regularly organized, immunization coverage has increased significantly increased and several cleanliness drives have been organized in the six new villages of Junagadh District.

Recommendation #11: *A local writer, preferably with a background in rural development and with some health experience, should be hired either as a consultant or full-time, to document at least five lessons learned/best practices of AKHS/I during the last two years of the current MG. The documentation produced by the AKHS,I should be disseminated throughout India and to the* widest possible audience in the developing world as well as elsewhere, e.g. international donor agencies.

- A new Documentation Program Officer started at the beginning of this year to attend to this particular assignment. A comprehensive lessons learned document will be available by the end of the project period. Specific focus will be given to the viability of both the facilitation and replication models of community-based health care systems.
- VOICES, a series of 5 testimonials highlighting the role and impact of community health workers was completed in September 2004 and is currently being distributed to key stakeholders.

Annex 8
Final Evaluation Report

	Strengths	Challenges	Recommendations
	Objective 1		
RRANGE OF SERVICES	ANC services in 1st trimester (49% Sidhpur; 51% Junagadh)	Women who take 90+ IFA (31% Sidhpur ; 38% Junagadh)	Conduct a cost benefit analysis of providing LHVs for 24hour availability to provide delivery services. If AKHS,I decides to continue to conduct deliveries, staff need to be trained on the use of partograph and maternal danger signs rather than just risks
	Institutional deliveries (69% Sidhpur; 47% Junagadh)	Few deliveries (3%) are done by AKHS,I Staff .	
		Greater awareness for post-partum care and use of PPC	
	Newborns weighed with 48hrs (62% Sidhpur; 66% Junagadh).	Breastfeeding within 1 hr of delivery(17% Sidhpur; 32% Junagadh).	.AKHS,I should further analyze the LBW rates in the project areas. Medical staff needs training on: re-calibration of scales and specific activities to manage LBW babies in the community.
		LBW Rate 21% Sidhpur; 12% Junagadh).	
	Fully immunized in Junagadh 81% and measles 84%	Fully immunized in Sidhpur 55% and measles immunization 58%	AKHS,I needs to further strengthen the following information, behaviors and services: 1) complete course of IF during ANC; 2) continued follow-up with PPC; 2) early & exclusive breast-feeding up to 6 months; 3) immunization coverage in Sidhpur; 4) use of ORS to treat diarrheas; 6) treatment of STI ;and 7) awareness of HIV/AIDS.
	Immunization of Hep B in Junagadh 55%	Immunization of Hep B in Sidhpur 24%	
	Children with ARI who sought treatment and received standard case mgmt (>85%)	Children with diarrhea who received ORS (16% Sidhpur; 25% Junagadh)	
	Use of permanent FP methods (>60%) and temporary FP methods (>30%)		
	Awareness of STIs/RTIs (63% Sidhpur; 42% Junagadh)	Women who receive STI treatment (44% Sidhpur; 38% Junagadh)	

ACCESS	**Standard Model:** shows that improved health status can be achieved with moderate levels of cost recovery. AKHS,I has direct control over quality of services	Higher cost model due to capitol investments.	AKHS,I should further document/ disseminate findings on critical factors that influenced the replication and facilitation models;
	Replication Model: was able to mobilize the comm.-unity relatively quickly because they began with broader representation from the outset. AKHS,I has direct control of the quality of the services that are provided and adjustments can be made easily.	Level of cost recovery is more sensitive to market forces (e.g., existing unmet demand for health services and competition) than the specific model.	
	Facilitation Model: shows that building on and mobilizing existing structures can benefit the community. Supporting community structures created locally ownership and created educated health care consumers who knew what services they should expect to receive. I GHSDP was able to improve the quality of services offered by private providers.	GHSDP was not able to train the ANMs who are key providers; it is unclear what level of quality they are able to provide to the community. AKHS,I has much less direct control over the quality of the services provided.	
	Staff highly committed. LHVs 24 hrs Available. High regards from Community. Client friendly environment.	High staff turnover	Continue to maintain quality staff

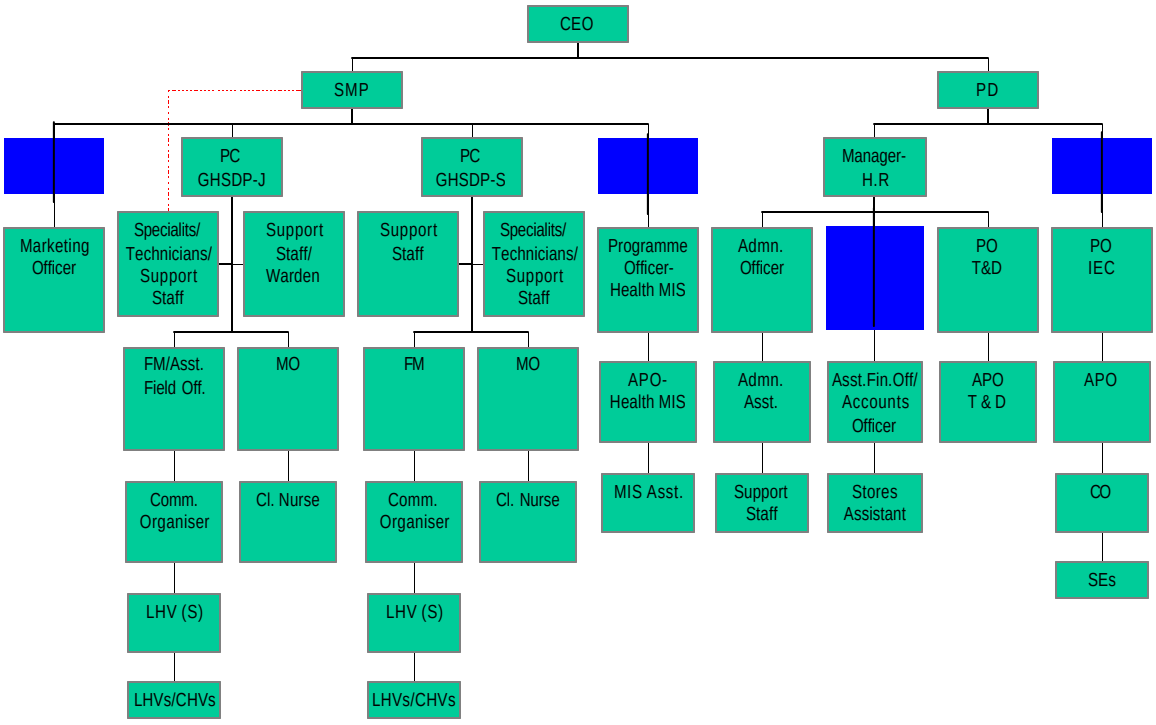
Table 4: Characteristics of GHSDP Service Delivery Models

	Strengths	Challenges	Recommendations
Objective 2: Organization Effectiveness			
Org Eff	AKHS,I has largely been a direct service provider. This worked when there was limited private sector competition and weak government systems; this has changed dramatically	Market competition	AKHS,I could further articulate the new roles that it could play in facilitating service delivery and providing technical support. Based on the changing role of AKHS, organization structures and staff competencies would need to be aligned.
HR	Two external reviews; resulted in an improved compensation package for AKHS, I employees, particularly LHVs. Efforts have been taken to implement creative solutions LHV/MO turnover (e.g.,. Use of MO interns from MGIMS; re-allocated of MO's time to cover several HCs profit-sharing arrangement with a radiologist.	Staff turn over was a major problem at all levels of the project, although it has been managed fairly well.	Develop a task force to understand what key policy issues AKHS,I should be involved with, either individually or collectively, based on the organization's comparative advantage and Mission
Capacity Building	AKHS, I conducted a training needs assessment and developed a two-year training plan and strategy.	Since Jan 2000 there has been 45 trainings, due to LHV turnover (40%).	

MIS	The LHVs spend between 30-40hr a month completing registers and forms. Registers are complete, there are some constant errors.	It seems that there is confusion on: 1) the type of data needed for program mgmt and those needed to monitoring health status; 2) linking the data that is recorded with the relevant health actions that are needed to manage the individual case; 3) the time frames which change can be expected among the indicators which would indicate how often data needed to be analyzed; and 4) how to operationalize the M&E plans/log frames. .	Mmgt and field staff should be trained on how to develop a log frame approach (Goal, Objectives, Impact, Outcomes, Outputs and Inputs) and how to operationalize. Data needed for program mgt and those for tracking health status should be identified and clearly link with the program objectives. The data to be collected and how often they are collected/ analyzed needs to be consistent with the expected change in objectives. The Team recommends the use of proxy indicators for program mgmt.
	The numbers of registers and forms were reduced. A MIS manual was developed; translated in Gujarati and staff was trained. In 2002 a custom-made software package was developed for the MIS.	Even though the numbers of registers and forms were reduced the pieces of data remained relatively unchanged.	The HH register should serve as a census rather than a monitoring system. It should be updated on a project need basis (e.g., yearly). Since FP information is included in the HH register, a separate FP/RH register should be developed.

Strengths	*Challenges*	Recommendations
Objective 3: Finical Management		
HCs were able to cover between 45-60% of their operating costs; 4/16 achieved almost 100% cost –recovery. HMSC members were very active in managing the HCs. Both areas were able to raise additional revenues other than user fees.	Cross-Subsidization model – profits from the DCs was not very effective because DCs could not generate enough surplus to shortfall of funds need by the HCs	HSMCs need support in managing the transition, particularly if there are large drops in utilization, requiring additional revenue streams. HSMC's need additional training in financial management, particularly standardization of financial registers, accounting of petty cash and credit and simple break-even analysis).
		AKHS,I staff need further training on: 1) cost analysis and financial management to assist the HSMCs better maintain their accounts. Further study on potential revenue sources (e.g., family insurance and dairy cooperatives). Conduct more analysis to better understand changing market conditions.
Objective 4: Documentation of Best Practices		
VOICES, a series of 5 testimonials highlighting the role and impact of community health workers,. Papers were presented at 2 international conferences. A lessons learned document of the project will be available by the Dec 2004.	Lack of an overall documentation strategy Documentation Officer hired in 2004..	Develop a documentation plan at the onset of projects, develop mechanisms to ensure documentation throughout the project life and reward staff for their efforts.
		AKHS,I should further document and disseminate findings on : 1) GHSDP/s work with Ismaili and non-Ismaili populations; 2) critical factors for the success of the replication and facilitation models; 3) guidance on inputs needed to scale-up service delivery models; 4) what can be expected in terms of cost-recovery under various market conditions and what are the key factors that enhance sustainability.
		It is strongly recommended that AKHS,,I write a journal article on its work in community-managed financial sustainability, particularly the factors that influence financial sustainability and levels that can be expected under certain
		Encourage projects to have a research/pilot component with specific M&E plans.

Annex 9
AKHS,I Organogram



CEO = Chief Executive Officer
SMP = Senior Manager, Programs
PD = Program Director
HR = Human Resources
PC = Program Co-coordinator
GHSDP, J/S= Gujarat Health System Development Project, Junagadh/Sidhpur, Patan
FM = Field Manager
MO = Medical Officer
APO = Assistant Program Officer
PO, T & D = Program Officer, Training and Documentation
PO, IEC = Program Officer, Information Education and Communication
CO = Community Organizer
SE = Social Educator
LHV = Lady Health Visitor
CHV = Community Health Volunteer

Project Staff to Beneficiary Ratios:

- **CHVs** – 1: 692
- **LHVs** – 1: 4,548
- **MOs** – 1: 17,625

Annex 10
Health Sector Management Committees/Village Level Committees Roles and Responsibilities

Health Sector Management Committees (Patan Distinct)/Village Level Committees (Junagadh District), comprised of a Convener, Secretary and members from the community, manage and monitor the functioning of Project activities at the village-level. The Committee meets monthly to monitor the activities of the health center and plays a central role in guiding Community Health Volunteers and facilitating community mobilization.

These bodies are responsible for the day-to-day management of health centers and for conducting outreach to the community.

Specific responsibilities include:

1) Managing and supporting health center staff, i.e. Medical Officers, Lady Health Visitors, Lady Health Visitor Supervisors and Community Health Volunteers
2) Identifying and mobilizing local resources
3) Networking with local public and private health care providers, other NGOs, dairy cooperatives, village-level governing bodies, etc.
4) Submitting a monthly report of activities and financial statements showing expenditure vs. income
5) Maintaining health, demographic and service statistics
6) Assisting in maintaining accounts and stock registers
7) Organizing health and screening camps and awareness activities

There are generally 7 to 9 members serving on each Committee. These management bodies are as yet not legally registered entities. Rather, they are governed by AKHS,I rules and regulations. However, there are plans once select Committees are sufficiently strong enough to stand alone to register them as autonomous entities.

Members are nominated by local community leaders and are appointed by the Chairman or Vice Chairman of AKHS, I's Board. Selection criteria include age, education, previous experience working with the community, acceptance by the community, and enthusiasm for voluntary work. Tenure on the Committee is for one year.

Annex 11
Community Mobilization Timeline

Replication Model: Patan and Banaskantha Districts

Activities Performed	Staff Responsible	Start Time	End Time	Time Taken
Preparation of strategy for entry into new villages of Sidhpur	Board of Directors, Senior Project Manager and Project Coordinator	June 2000	September 2000	4 months
Listing of potential additional villages in Sidhpur	Project Coordinator	October 2000	October 2000	1 month
Meeting with village and local leaders	Project Coordinator and Community Organizer	November 2000	December 2000	2 months
Finalization of 3 villages in which to test the Replication model of service delivery	Project Coordinator	January 2001	January 2001	1 month
Information Education Communication sessions and rapport-building undertaken	Community Organizer and Lady Health Visitor (Supervisor)	February 2001	March 2001	2 months
Selection of Health Sector Management Committees and Community Health Volunteers	Community Organizer	April 2001	April 2001	1 month
Household survey undertaken to obtain village-wise demographic information	Community Organizer and Lady Health Visitor	April 2001	May 2001	2 months
Visit of and motivation by senior managers	Community Organizer and Senior Managers	June 2001	June 2001	1 month
Decision about location of health centers	Project Coordinator and Community Organizer	July 2001	July 2001	2 months
Orientation imparted on role of Health Sector Management Committees and Community Health Volunteers	Community Organizer and Social Educator	July 2001	July 2001	1 month
Inauguration of health centers	Project Coordinator, Community Organizer and Lady Health Visitor (Supervisor)	July 2001	August 2001	2 months
Signing of Memorandum of Understanding between Aga Khan Health Service, India and Health Sector Management Committee	Project Coordinator	August 2001	September 2001	2 months
Orientation of Health Sector Management Committee	Community Organizer	October 2001	October 2001	1 month
Training of Community Health Volunteers	Community Organizer and Lady Health Visitor (Supervisor)	December 2001	January 2002	2 months
Continuous Information Education Communication sessions, mass meetings and household visits	Lady Health Supervisors and Community Health Volunteers	February 2002	Onwards	N/A
Facilitation of monthly Health Sector Management Committee meetings	Community Organizer	December 2001	Onwards	N/A
School health Family Life Education program starts	Community Organizer and Social Educator	May 2002	Onwards	N/A
Health Sector Management Committees started organizing screening camps for Hep. B	Lady Health Visitor (Supervisor)	July 2002	Onwards	N/A
Vaghrol Health Sector Management Committee interested in constructing new center	Community Organizer	June 2003	Onwards	N/A
New Health Sector Management Committee Elected in Wadhana	Project Coordinator, Community Organizer and Lady Health Visitor (Supervisor)	June 2004	Jul-04	1 month

Facilitation Model: Junagadh District

Activities Performed	Staff Responsible	Start Time	End Time	Time Taken
12 villages short listed on the basis of selection criteria	Community Organizer	June1999	July 1999	2 months
Village identification	Community Organizer	July 1999	December 1999	6 months
Village level meeting with village and local leaders	Community Organizer	December 1999	March 2000	4 months
Rapport-building with the community	Community Organizer and Social Educator	April 2000	November 2000	8 months
Visit of and motivation by senior managers	Community Organizer	August 2000	N/A	N/A
Development of Letter of Intent to become stakeholders	Community Organizer and Social Educator	November 2000	April 2001	6 months
Meeting on role of facilitator and identification of Village Level Committees and Community Health Volunteers	Community Organizer and Social Educator	January 2001	May 2001	5 months
Orientation of Village Level Committees	Field Manager, Community Organizer and Social Educator	July 2001	August 2001	2 months
Election of new Village Level Committee members	Field Manager, Community Organizer and Social Educator	November 2001	December 2001	2 months
Participatory Rural Appraisal	Field Manager, Community Organizer and Social Educator	April 2002	May 2002	2 months
Refresher training for Village Level Committees	Field Manager, Community Organizer and Social Educator	July 2002	August 2002	2 months
Identification of local public and private health providers	Community Organizer, Social Educator and Assistant Field Manager	February 2002	N/A	
Formation of Apex Body: At least one representative of each Village Level Committee per village	Community Organizer, Social Educator and Assistant Field Manager	December 2002	January 2003	2 months
First training of Traditional Birth Attendants	Field Manager, Community Organizer, Social Educator and Assistant Field Manager	February 2003	N/A	N/A
Training of Anganwadi Workers	Field Manager, Community Organizer, Social Educator and Assistant Field Manager	March 2003	N/A	N/A
First training of public and private providers	Field Manager, Community Organizer, Social Educator and Assistant Field Manager	November 2003	N/A	N/A

Annex 12
Family Life Education Criteria

Sr. No.	Curricular Subject Matter
1.	Orientation to the FLE Program
2.	Introduction to the Male Reproductive Organ
3.	Introduction to the Female Reproductive Organ
4.	Changes During Puberty in Males and Females
5.	Process of the Menstrual Cycle
6.	Problems Related to Menses
7.	Process of Conception
8.	Development of Fetus in the Womb
9.	Importance of ANC, PNC and Safe Delivery
10.	Safe and Unsafe Abortion and Related Social Issues
11.	Sexually Transmitted Diseases in Males and Females
12.	HIV/AIDS (Audio-Video Show)
13.	Family Planning and Safe Sex Practices
14.	Gender Equity
15.	Family Relationships
16.	Role of Students in Drug De-Addiction
17.	Importance of Discipline in Life
18.	Importance of Education in Life
19.	Importance of Environment Sanitation in Rural Areas
20.	Mental Health and Stress Management
21.	Importance of Nutrition in Life
22.	Preventable Illness and Non-communicable Diseases
23.	Post FLE Program Assessment

Annex 13
Exit Strategy Plan

Background

As per the Detailed Implementation Plan of the *Gujarat Health Systems Development Project* (GHSDP), a strategy is currently being formulated in response to the sub-objective of "handing over" two health centers to the community by December 2004. The key points and issues of concern are documented herewith to apprise the reader of this process.

Process

With assistance from AKF,I, AKHS,I presented a strategy paper for the "handing over" of health centers to their Board of Directors on 18th May 2003, after which they held meetings with Dr. John Tomaro (Program Director, AKF – Geneva) and AKF, I. Based on the outcomes of the above meetings, the following strategies have been suggested as preliminary guidelines to direct the process of "handing over", with identified risk areas informing the development of the strategy at different levels.

A major outcome of said meetings is that the GHSDP project team has decided to "hand over" only the Methan and Meloj health centers in Patan District, and not those in Chitravad and Malia, Junagadh as previously discussed.[2] Moreover, "handing-over" in the Sidhpur area of Patan has been defined as "complete management of basic operations" and not "ownership" of the health center assets, thereby building upon the current management system implemented by the Health Sector Management Committee (HSMC).

Methan and Meloj are located within Sidhpur area of Patan District, Gujarat State and both have approximate populations of 3,000. There is a large demand for and utilization of curative services provided by the health centers in each village. Methan is 97% self-sufficient in its operational costs whereas Meloj falls slightly behind at 77%. Both health centers operate Community Health Fund schemes and respectively earn INR 20,000 and 8,000 per year in user fees. Strong linkages are present with their local Dairy Cooperatives, with Methan annually receiving INR 15,000 and Meloj 30,000. These health centers enjoy the active involvement of their HSMCs, which are competent in running the day-to-day operations of the centers, and are well poised and prepared for the process of "handing over" (See Annex 1 for more information on Methan and Meloj health centers).

To initiate the process and help develop an overall strategy, the following work must be completed:

Strategy Plan

1. Analyze the existing status of Methan and Meloj in terms of present health status, availability and accessibility of health services, service utilization trends, programmatic

[2] Decision based on current cost recovery rates and level of effort estimated for handing over centres.

self-sufficiency levels, existing managerial capacity, status of infrastructure, and value of assets.

2. Mobilize communities to form a consensus among existing HSMCs and village leaders about the composition, selection term/duration and role of the HSMC and legal status of the new health center management body.
3. Ensure the new health center management bodies have proportional representation of equal numbers of men and woman across ethnic groups in the village to instill in them a sense of collective entitlement.
4. Form the new health center management body and build its technical capacity.
5. Develop a business plan with inputs from the new health center management body encompassing innovative utilization strategies, diversified revenue sources, and risk management plans for the next five years.
6. "Hand over" the health center

The table below illustrates the capacity building and managerial areas among which responsibilities of both AKHS,I and the health center management bodies will be divided after the process of "handing over" has occurred.

Sr. No.	Responsibility	Aga Khan Health Service, India	Health Center Management Body
1.	Technical Capacity Building	• Human resource management and development • Quality assurance • Initiation of new programs • Management of epidemics and medico-legal cases • Audits and evaluation of services/programs • Documentation and dissemination	--------
2.	Institutional Capacity Building	-------	• Establishing linkages with other organizations (Government of Gujarat, NGOs, village-level governing bodies, community-based organizations, self-help groups, dairy co-operatives, etc.)
3.	Financial Management	--------	• Defining pricing policies and ensuring collection of revenue, especially from defaulters • Operation of bank account • Maintaining financial records • Generating and analyzing financial reports
4.	Logistics Management	• Procurement of medicines and equipment	• Supply Management • Repair and maintenance of built structures

5.	Human Resource Management and Development	• Recruitment, hiring, termination, staff benefits/welfare	• Monitoring staff (attendance, leave, performance, etc). • Staff retention • Quality assurance

Long-term Issues

With respect to the name of the health centers, if they are to be changed so as to reflect the name of the village only, a by-line will be created highlighting the health center's relationship to AKHS,I, the Dairy Cooperatives and Panchayat institutions. However, if the names are to remain as is, the health center will be "handed over" to the new management bodies on a franchise basis. In this case, if the registered management body does not satisfactorily operate the health center as per AKHS,I terms and conditions, AKHS,I will possess full authority to reclaim complete management responsibilities. Therefore, maintaining the image and credibility of the new health centers in the future will require close attention in deciding the name and legal/ownership status of the health centers prior to "handing over".

As the new management body's self-sufficiency level rises, there is likely to be an increase in the desire of communities to exercise control over important dimensions of health center staff and services. At the health center level, this desire may bring local community leaders into greater conflict with managers of the overall system, the latter of whom the centers rely upon for purchasing of stocks, recruitment, quality assurance and technical support. As such, the process of determining the long-term legal status of the new health center management bodies should be initiated through consultations once the bodies have been formed. Consensus is on the side of registering the management bodies as trusts that have linkages with both Dairy Cooperatives, Panchayat institutions, with representation from both these village organizations on the Board of Trustees (See Annex 3 for details).

Risks Foreseen

The following are risk areas identified by AKF, I and AKHS, I:

1. New health center management bodies may not be able to operate and manage health center activities efficiently enough to sustain them in the long-term at par with quality standards of care.
2. Resistance within the existing HSMCs to internal restructuring, the latter of which may or may not have the desired effect of fostering a sense of community ownership and the associated rise in utilization rates.
3. Market for the services offered may shift unfavorably away from the services offered
4. Conflict between the need to simultaneously assure affordable prices, quality care, equal access and financial sustainability.
5. Issue of felt versus unfelt needs. Felt needs are services in demand and for which people are willing to pay. Servicing felt needs is what generates revenue from user fees, upon which financial sustainability rests. However, servicing unfelt needs is equally as important

as prevention, promotion, and health education have a significant impact on improving health status.

Annex 1 provides details of the existing status of the two health centers to be handed over
Annex 2 contains a timeline for the process of handing over
Annex 3 is a table comparing the different approaches of establishing the health centers either as cooperatives or trusts in the long-term

Annex 14
Summary of Replication and Facilitation Models

Replication Model Implementation Cycle

PHASE	ACTIVITY	OUTPUT	CHALLENGE
Village Selection	• Determination of criteria • Community sensitization (meetings with key community leaders)	• Village identified and selected	
Community Mobilization	• Meetings with village leaders and community-based organizations • Identification of building to be converted into health centers • Communication: Audiovisual shows, street plays, etc.	• Health Sector Management Committees formed • Health center site chosen • Community Health Volunteers selected • Memorandum of Understanding signed between AKHS,I and HSMC	• Misunderstanding of division of labor between AKHS,I and HSMC • MoU not signed • Lack of cross-sectional community participation • Low participation of women
Health Needs Assessment	• Village mapping • Participatory Rural Appraisal • Participatory Learning for Action • Focus Group Discussions • Key Informant Interviews • Health facility assessment • Health seeking behavior assessment	• Key health issues identified • Health infrastructure mapped	
Program Strategy	• Mobilizing staff (Medical Officers and Lady Health Visitors) • Development of training manual for HSMC and CHVs • Prepare list of equipment for health centers • HSMC orientation and training • Networking with public and private providers	• Staff capacity built • Training manual developed • HSMC and CHVs oriented and trained • List of required health equipment developed • Linkages established with public and private providers	• Poor networking with public and private health care providers • Insufficient trainings
Initial Preparation	• Construct and/or renovate health center • Procure equipment and medicine • Train HSMCs, CHVs, field and medical staff	• Health centers built and renovated • Equipment and medicine procured • Trainings conducted	• Frequent delay in drug procurement

PHASE	ACTIVITY	OUTPUT	CHALLENGE
Program Implementation	• Out Patient Service Delivery at health center • Satellite clinics offering ANC, growth monitoring and immunizations • Health and screening camps • BCC activities • Record-keeping • Updating MIS registers • Ongoing training of HSMCs, CHVs and medical staff • Monthly HSMC meetings • Establishment of referral system to quality public and private providers	• Effective management and administration of health centers • Affordable and accessible quality primary health care services provided to the community • Increased community health awareness and behavior change • Referral system established • Updated records and registers	• Inconvenient health center timings • High LHV attrition rate • Poor collaboration with public and private providers • Insufficient BCC material and activities • Overburdened LHVs • Inefficient data collection, entry and analysis resulting in poor monitoring
Exit Strategy	• Meeting with HSMCs, CHVs, village leaders, public and private health providers • Revision of Memorandum of Understanding • Clarification of roles and responsibilities in managing health center	• Key community stakeholders involved in exit strategy planning	
Withdrawal	• AKHS,I to provide continued technical assistance and quality assurance • Project staff withdrawn	• New Memorandum of Understanding signed • Staff withdrawn • Continual technical support provided	

Facilitation Model Implementation Cycle

PHASE	ACTIVITY	OUTPUT	CHALLENGE
Village Selection	• Determination of criteria	• Villages identified and selected	
Community Mobilization	• Meetings with village leaders and community-based organizations on role of AKHS,I as facilitator of service delivery • Visit of and motivation by Senior Managers	• Village Level Committees formed • Community Health Volunteers selected • Development of Letter of Intent for Village Level Committees to become stakeholders	• Misunderstanding of division of labor between AKHS,I and VLC
Health Needs Assessment	• Village mapping • Participatory Rural Appraisal • Participatory Learning for Action	• Key health issues identified • Health infrastructure mapped	
Program Strategy	• Identification of local public and private providers • Orientation and training of Village Level Committees • Formation of Apex Body (comprised of at least 1 Village Level Committee representative per village) • Networking with public and private providers	• Volunteer and provider capacity built • Apex Body formed • Linkages established with public and private providers • Active and aware village level committees • Broad community participation	• Minimal participation by private providers • Insufficient trainings
Initial Preparation	• Train Traditional Birth Attendants, Anganwadi Workers and Auxiliary Nurse Midwives • Train private providers (quality assurance and rational drug therapy)	• Trainings conducted • Links with public providers build to enhance access to services	• Not ANMs who were trained provided services
Program Implementation	• Satellite clinics offering ANC, growth monitoring and immunizations • Health and screening camps • BCC activities • Ongoing training of all participants (VLCs, CHVs, ANMs, TBAs, private providers) • Monthly VLC meetings	• Increased community health awareness and behavior change • Referral system in place and operational • Improved provider practices and quality of services. • Increased desire for participation amongst other private providers in the area	• No direct benefits perceived by the people in short-term, i.e. health center, service delivery, etc.

PHASE	ACTIVITY	OUTPUT	CHALLENGE
	• Establishment of referral system to quality public and private providers		
Exit Strategy	• Meeting with VLCs, CHVs, village leaders, public and private health providers		• Clear exit strategy not in place from the outset. • Poor documentation of process, activities and impact
Withdrawal	• Project staff withdrawn	• New Letter of Support signed • Staff withdrawn	• Reliance on Social Educator • Continued Support from Government not guaranteed

Facilitation Model: Description of Apex Body

Purpose: The Apex Body is a component of the *facilitation* model of expansion of health services under the revised mandate of GHSDP. Its activities complement existing primary health care services provided by the Government of Gujarat as these government services do not extend coverage throughout all areas of Gujarat.

Geographical Location: 6 added villages in Junagadh District (Matarvania, Bodi, Viradi, Katrasa, Devgam, and Jallander).

Organizational Structure: The Apex Body is a partnership between Village-Level Committees and public and private health care providers. The latter are a group of health care service providers already operational in Junagadh consisting of indigenous healers, semi-qualified medical practitioners and government workers such as Traditional Birth Attendants, *Anganwadi* Workers (day care workers), Community Health Workers, and Auxiliary Nurse Midwives. Apex Bodies also comprise at least one Village Level Committee representative from each village.

Activities: The Apex Body convenes monthly meetings in which Village Level Committee members meet with public and private providers to discuss the health needs of the community and jointly devise strategies to address such needs using the services, infrastructure and human capital already available in the community.

Role of AKHS, I: AKHS,I acts as a facilitator between the Village Level Committee and public and private providers. Either the Field Manager, Project Co-coordinator or Community Organizer from the field office in Junagadh attend the monthly meetings to be of assistance in an advisory capacity, particularly in order to ensure quality in the health care outcomes of the Apex Body. AKHS,I generates awareness on health issues faced by the community while simultaneously building the capacity of public and private providers to respond to the needs of the community.

Annex 15
Trainings Imparted Since Project Inception

Year 1: October 1998 – September 1999

Training	Date	Duration	#Attendees	Person-days	Category of Staff/Volunteers
Microsoft Office Package	April 1999	1	10	10	Mid and Senior Managers
Refresher on Communicable and Non-Communicable Diseases	July 1999	2	42	84	Lady Health Visitors and Supervisors
PAP Smear	July/August 1998	2	24	48	Lady Health Visitors – Junagadh
Computer Hardware/Software maintenance and introduction to new MIS format	August 1999	1	6	6	Field Office Staff
RCH/IMNCI	August 1999	3	30	90	Executives, Managers and Field Office Staff

Year 2: October 1999 – September 2000

Training	Date	Duration	# Attendees	Person-days	Category of Staff/Volunteers
Counseling Skills	October 1999	3	8	24	Mid and Senior Managers
Primary Health Care MAP Modules	October 1999	7	16	112	Health Professionals from NGOs across India
Performance Management	November 1999	2	14	28	Senior Staff
Professionalism in Health Care	January-February 2000	2	140	280	All Staff and Senior Volunteers
CHV Orientation	January 2000	2	41	82	CHVs
RCH–IMCI	March 2000	3	35	105	Field Office Staff
Field-based training for new LHVs	March 2000	9	9	81	Lady Health Visitors

Year 3: October 2000 – September 2001

Training	Date	Duration	# Attendees	Person-days	Category Staff/Volunteers
Cost and Sustainability Analysis	April 2001	2	10	20	Managers and Finance Staff
MIS workshop	May 2001	2	15	30	All Staff
Mental Health	May 2001	2	45	90	Senior volunteers and project staff
Essential Health Services	July 2001	4	16	64	Project Coordinators, Field Managers and Community Organizers
Phase I: Training of Trainers	August-September 2001	3	22	66	Project Coordinators, Field Managers and Community Organizers
Nutrition	September 2001	2	38	76	Lady Health Visitors, Social Educators and Community Organizers

Year 4: October 2001 – September 2002

Training	Date	Duration	# Attendees	Person-days	Category Staff/Volunteers
Phase I: Sexually Transmitted Infections and Reproductive Tract Infections	November 2001	3	44	132	Lady Health Visitors, Community Organizers, Social Educators and Field Managers
Documentation	December 2001	3	35	105	Mid level Managers
Participatory Rural Appraisal/Participatory Learning for Action	February 2002	4	35	140	Core Trainer Group
Behavior Change Communication (BCC)	August 2002	6	46	276	Lady Health Visitors, Community Organizers, Social Educators and Community Health Volunteers
Safe Delivery	July-September	1	18	18	Lady Health Visitors

	2002				Supervisors
Dissemination of Protocols	September 2002	3 days each of 3 batches	45	135	Lady Health Visitors, Social Educators and Community Organizers
Phase II: Training of Trainers	September-October 2002	3	22	66	Project Officers, Field Managers and Community Organizers
Performance Appraisal	October 2002	2	8	16	Mid and Senior Managers

Year 5: October 2002 – September 2003

Training name	Dates	Duration	# Attendees	Person-days	Category of Staff/Volunteers
Family Life Education	November 2002	2	37	74	Lady Health Visitors
Integrated Management on Childhood Illnesses (IMCI)	November 2002	3	45	135	Lady Health Visitors, Social Educators, Community Organizers and Health Volunteers
Phase III: Training of Trainers	December 2002	3	22	66	Core Group of Trainers
Phase II: Sexually Transmitted Infections and Reproductive Tract Infections	December 2002	1	44	44	Lady Health Visitors, Field Managers, Community Organizers and Social Educators
Phase I: Safe Delivery for Traditional Birth Attendants	February 2003	3	31	93	Traditional Birth Attendants – Junagadh District
Essential Health Services	February 2003	2	45	90	Lady Health Visitors, Field Managers, Community Organizers and Social Educators
Infant Feeding and Childhood Nutrition for Effective Growth Monitoring	March 2003	2	26	52	Community Health Volunteers and Anganwadi Workers
Finance for Non- Finance Managers	April 2003	2	12	24	Administrative and MIS Staff
Phase II: Safe Delivery for Traditional Birth Attendants	September 2003	2 days in 2 batches	31	62	Traditional Birth Attendants – Junagadh District

Mental Health	September 2003	3 days in 3 batches	18	54	Project Coordinators, Field Managers, Lady Health Visitors, Community Organizers
Mental Health: Project Management	September 2003	3	4	12	Project Coordinators, Administrative and Human Resources Staff
Geriatrics and Exposure to Non-communicable Diseases	April 2003	3	46	138	Lady Health Visitors, Community Health Volunteers, Community Organizers and Social Educators

Year 6: October 2003 – September 2004

Training	Date	Duration	# Attendees	Person-days	Category Staff/Volunteers
• Rational Drug Therapy • Standard Drug Regimes • Reproductive and Child Health • Communicable and Non-communicable Diseases • Quality Assurance	November 2003	3	8	24	Private Practitioners-Junagadh District
Health and Nursing Protocols	May 2004	3 days in 3 batches	32	32	Lady Health Visitors, Social Educators and Community Organizers
• Household Visits • Information Education Communication • Quarterly Reporting	September 2004	5	4	20	Social Educators
Health and Nursing Protocols	May 2004	3	10	30	Lady Health Visitors
Health Center and Medical Equipment Maintenance	June 2004	1/2	25	12.5	Lady Health Visitors
Phase I - Refresher on Mental Health	March 2004	2	16	32	Medical Officers and Counselors
Phase II - Refresher on Mental Health	April 2004	3	21	63	Medical Officers and Counselors
Phase III - Refresher on Mental Health	May 2004	2	20	40	Medical Officers and Counselors
Phase I: Community Health Worker Training (for follow-on project)	September 2004	15	23	345	Community Health Volunteers

Annex 16
Behavior Change Communication Materials Developed

Type of Materials	Topics Covered	# Copies	Category of Staff Used By	Location Used
Flash card	Family Planning	1	1. Lady Health Visitors 2. Social Educators 3. Community Organizer 4. Community Health Volunteers	1. Household 2. Community 3. School 4. Health Center
Flash card	Ante and Postnatal Care	10		
Flash card	Breastfeeding	2		
Flash card	Anemia	4		
Flash card	Diarrhea	7		
Flash card	Safe Drinking Water	1		
Flip book	Tuberculosis	1		
Flip book	Essential Health Service Messages	1		
Flip book	Safe Delivery	1		
Flip book	Oral Cancer	1		
Flip book	Cervical Cancer	1		
Flip book	Throat Cancer	1		

Annex 17
Definitions of Alternative Health Financing

The project utilizes several forms of Alternative Health Financing (AHF) to decreases beneficiaries' dependence upon AKHS,I as the financial guarantor of their access to health care. By the same token, AHF increases utilization of the project's essential health services, coverage of primary health care in the project area and financial sustainability of the network of facilities.

The following are the four types of AHF implemented under GHSDP:

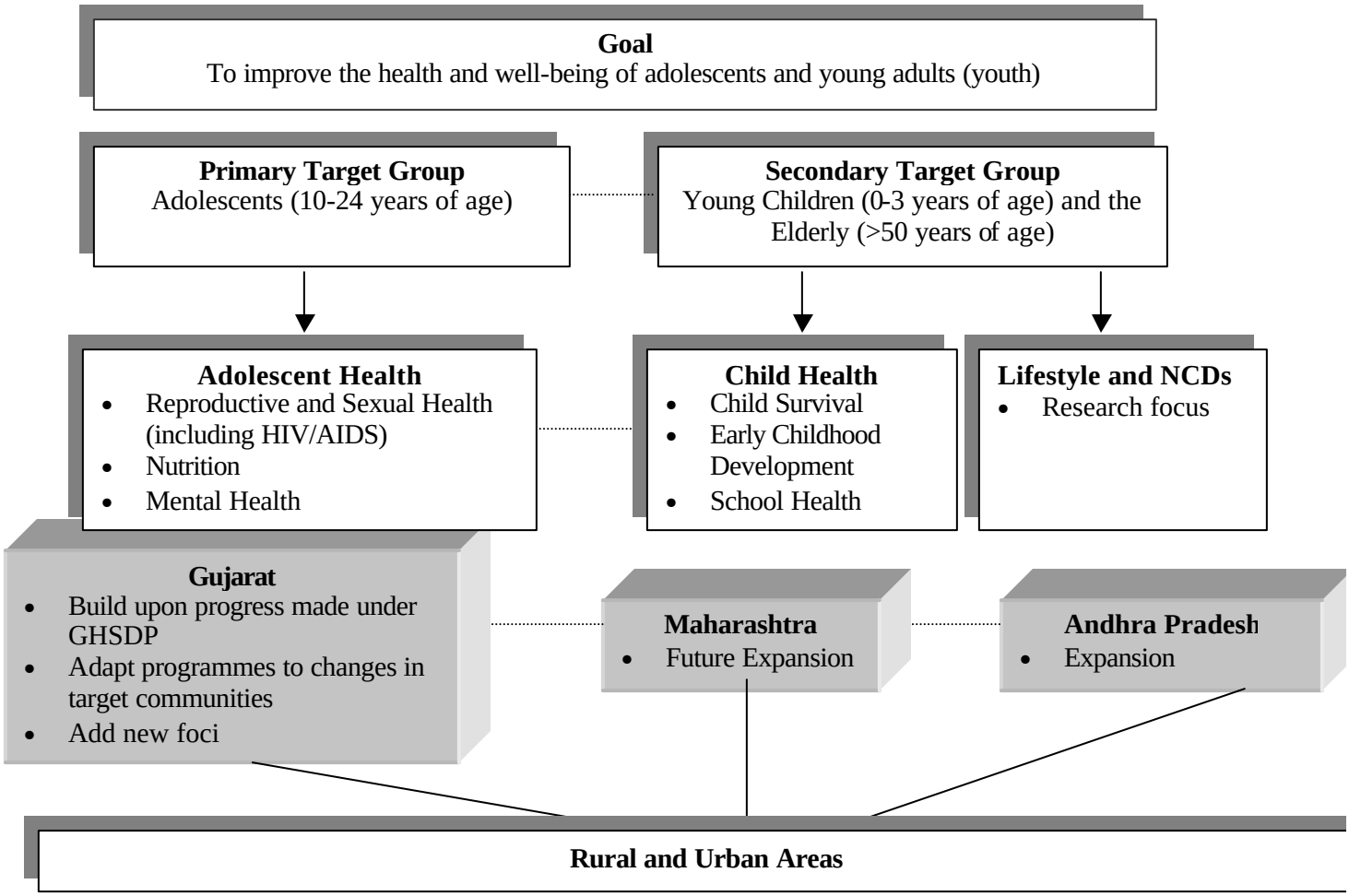
1. **Linkages with Diary Cooperative Trusts:** Annual lump sum monetary contributions made by local Diary Co-operatives in Methan and Meloj villages of Patan District are used to cover the operations costs of these two health centers. These sums are generated by putting away a small portion of the money received from each liter of milk sold to local villagers;
2. **Community Health Fund**: The Community Health Fund is a mechanism of pre-paid health insurance by which the project provides primary health care services to poor rural families for a mere INR 150/year. This in turn also contributes towards the overall financial sustainability of the project's network of facilities;
3. **Cross-subsidization**: Cross-subsidization is a means of increasing financial sustainability whereby revenues from diagnostic centers are used to off-set the operations costs incurred at health centers as user fees levied at health centers cannot recover these costs alone;
4. **Health and Screening Camps**: Funds generated through promotive health camps and preventive screening camps conducted by LHVs at the village level for pap smears, eye check-ups, immunization, etc. also play a part in subsidizing health center operations costs.

Basic health insurance plan provided through the Community Health Fund:

Terms and conditions
The service package will be issued for a 12-month period
The annual charge is INR 150 per family (Family size up to 4 members)
An extra charge of INR 40 is to be paid per additional members of the family
Other additional charges may also be levied as per the pricing policies of each individual health center
Benefits for the Package Holder
OPD registration fee waived
Physician's consultation fee waived
NCD check-up fee waived (only for those above 30 years of age) - Examination of B.P. - Height and weight - Urine Examination (once in a quarter)
ANC check-up fee waived
20 % discount for institutional deliveries
20 % discount at diagnostic centers in Keshod and Maliya (for Pathology services)

Advantages for the network of facilities and the Project
Utilization of centers will increase for: • OPD services • Delivery services • Laboratory services Increased coverage of primary health care Increased ANC coverage by timely registrations of pregnant women Increased NCD coverage Increased anemia control by regular checkup of Hb% Timely identification of malnutrition and follow-up Increased safe deliveries by trained personnel
Potential Challenges
Maintaining the continuity of staff at health and diagnostic centers Maintaining high standards and quality of care

Annex 18
AKHS,I Future Strategy Framework



Role

Service Delivery (w/ indicator-based measurement of impact throughout intervention)

Cross-Cutting Themes

- Gender
- Health Financing and Equity
- Private and public partnerships
- Health and Entrepreneurship Development (especially for women given the link between women's economic and health status)

Partners

1. AKES, AKRSP, AKPBS (will address issues of relevance to their institutional and programmatic scope of work in the same areas where AKSH,I is present)
2. Continue existing networking with Government of Gujarat
3. Look to other NGOs for effective models of integrated adolescent health programmes